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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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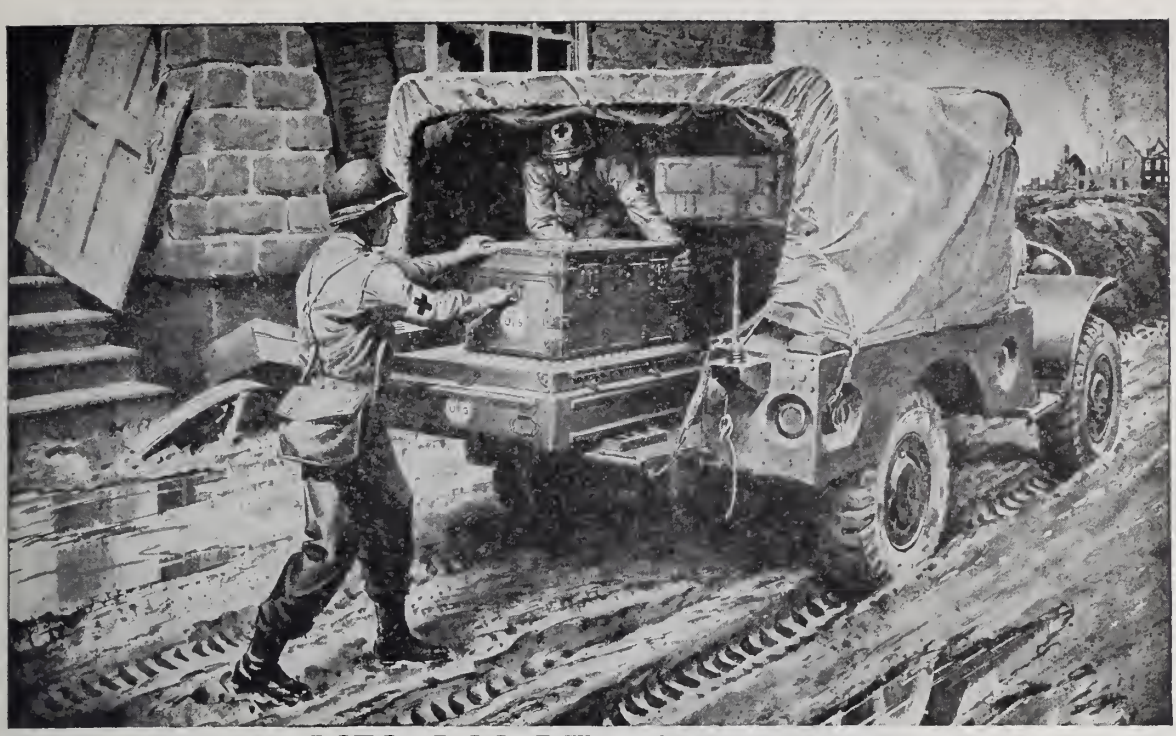
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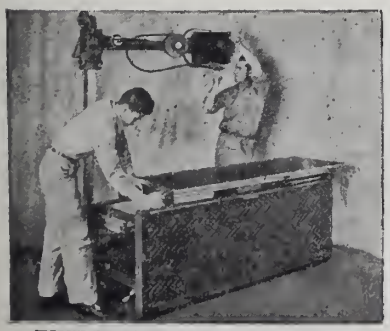
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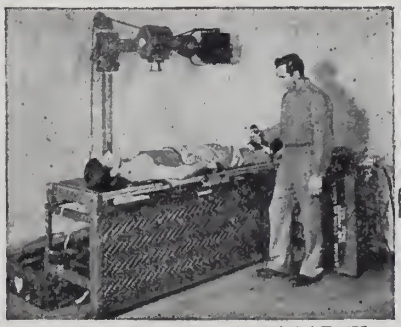
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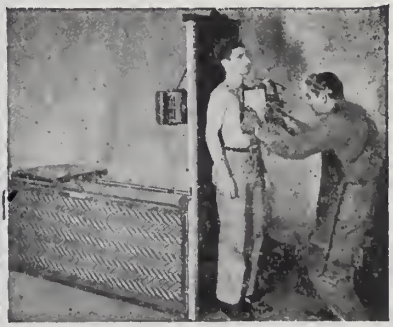


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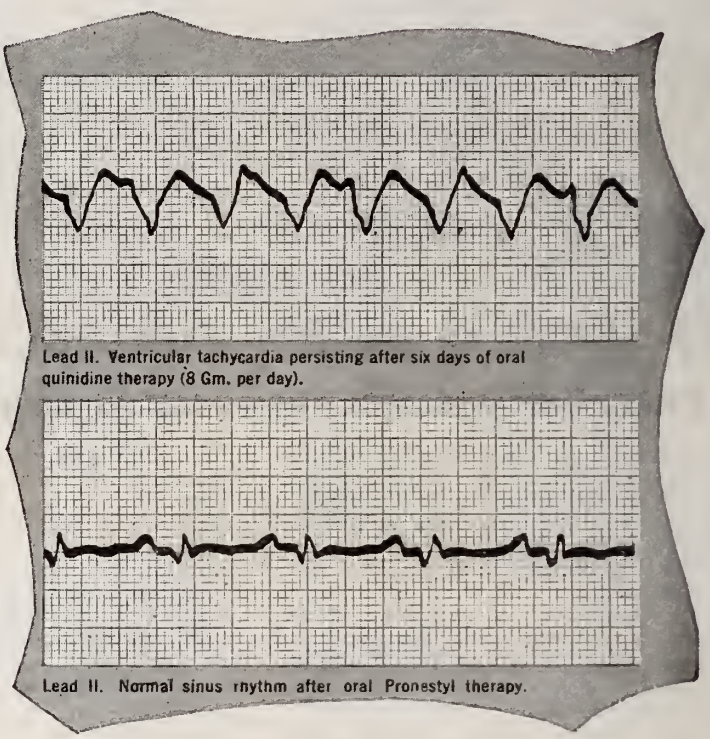
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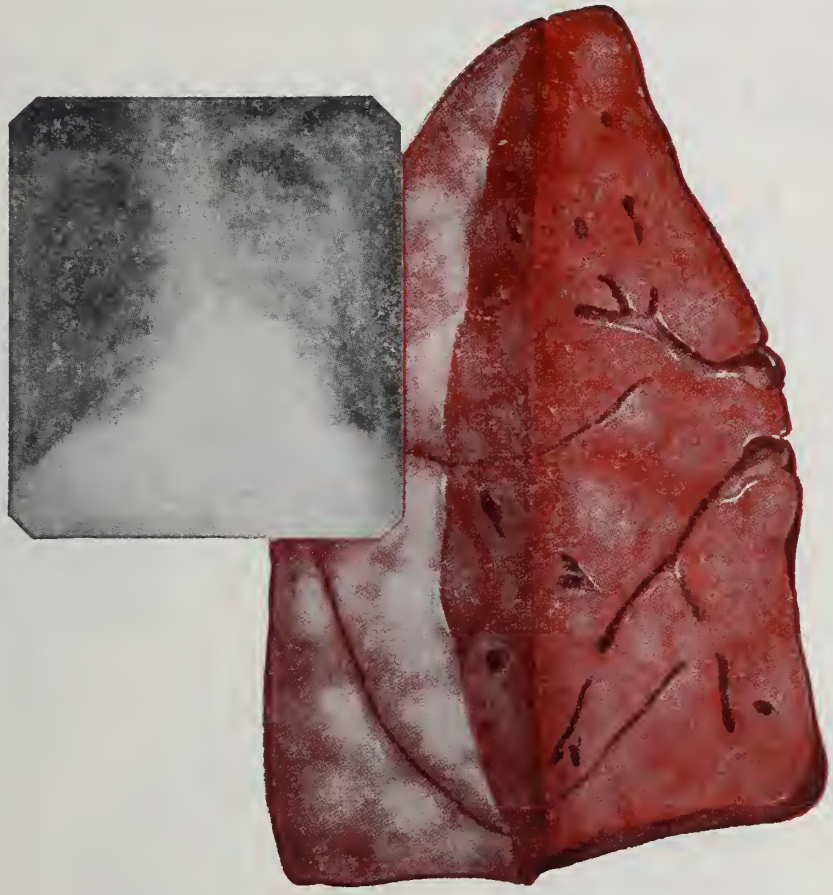
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1. Perloff, W. M.: Am. J. Obst. & Gynec. *58*:684, 1949.

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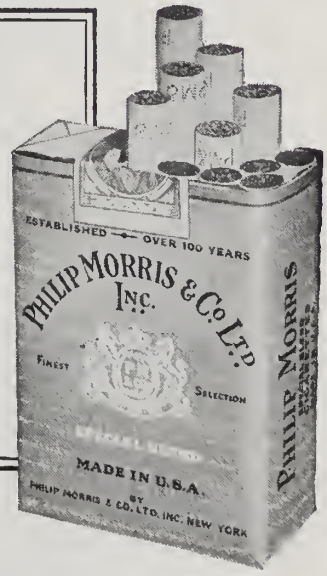
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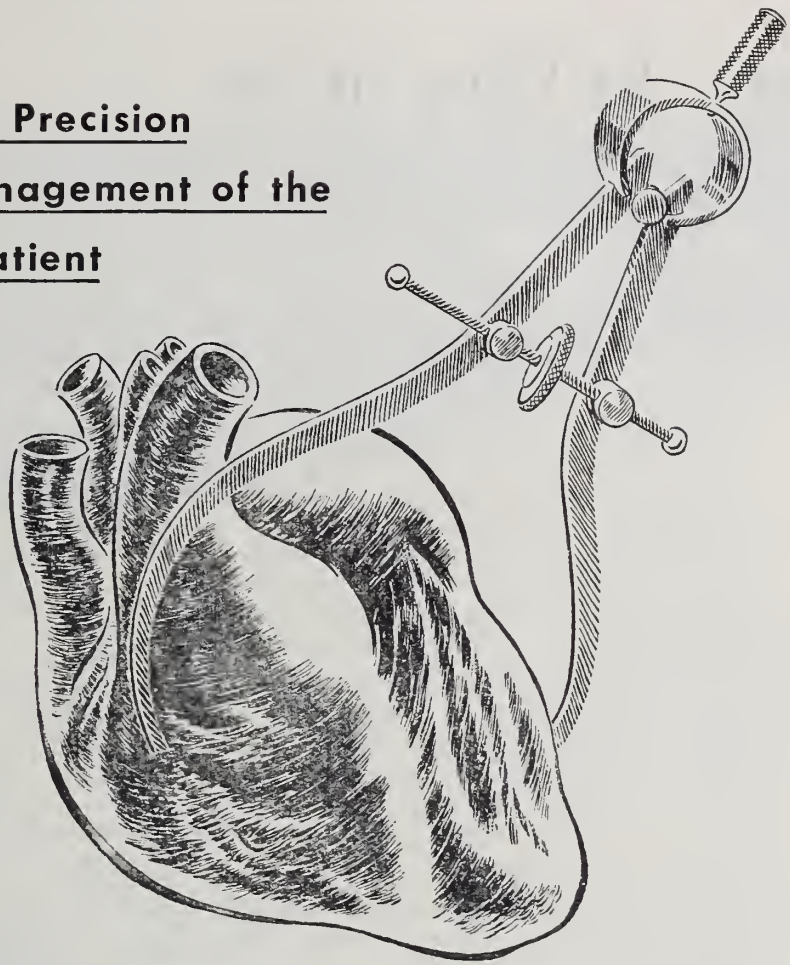
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Meat... Its Place in the Dietary Management of Nephritis

The formerly held tenet that protein intake should be restricted for all patients with impaired renal function, in order to afford the kidney physiologic "rest," is no longer valid.[1] Except for infection and some neoplastic and traumatic disorders, the treatment of renal disease is nonspecific and essentially symptomatic. The clinical problem centers largely on diet regulation, in the hope of stimulating the kidneys to improve impaired function, without unduly risking harm.

Even in the presence of azotemia, a protein intake of 60 to 80 Gm. per day has not been found harmful to the renal patient. Low protein intake, on the other hand, together with urinary loss of protein may encourage the development of asthenia, anemia, hypoproteinemia, and edema.[2] Also pertinent to the dietary management in renal disease is the experimental finding that high protein diets in normal dogs promote higher urea clearance and greater renal blood flow than do low protein diets.[3,4]

Except in anuria, a protein intake adequate to maintain nitrogen balance has been suggested.[1] Although as little as 30 to 40 Gm. of protein per day may suffice for this purpose in the fever-free patient at bed rest, few occasions arise when 1 Gm. of protein per day per kilogram of body weight may not be given safely. In the presence of significant proteinuria, unless specifically contraindicated, the dietary protein may be increased beyond that amount in order to counterbalance the urinary protein loss.

Contrary to the still prevalent ancient belief among the laity, red meats are just as harmless to the renal patient as white meats; nor is there evidence that plant proteins are more beneficial in nephritis than animal proteins. As with the normal person, the dietary protein of the patient should be of high biologic value.

Meat, because of its high content of biologically complete protein, may contribute valuably to the protein needs of the nephritic patient. The nutritional importance of meat, however, is not limited to its contained protein. Meat also contributes highly significant amounts of iron and of the vitamin B complex, including niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and the newly discovered vitamin B_{12}. Other salient features of meat in the dietary of the patient are its high palatability, its stimulation of the digestive processes, its satiety value, and its easy and practically complete digestibility.

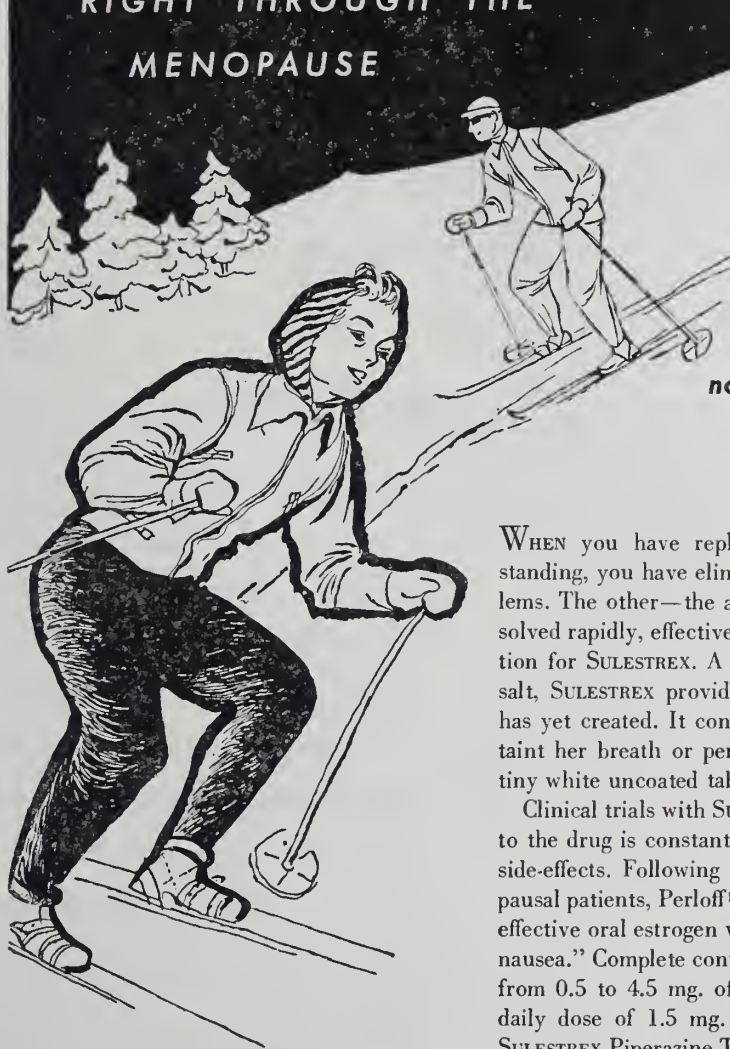
1. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, chap. 17, p. 351.
2. Weiss, S.: Diet and Bright's Disease, Connecticut M. J. 5:496, 1941.
3. Jolliffe, N., and Smith, H. W.: The Excretion of Urine in the Dog: II. The Urea and Creatinine Clearance on Cracker Meal Diet, Am. J. Physiol. 99:101, 1931.
4. Van Slyke, D. D.; Rhoads, C. P.; Hiller A., and Alving, A.: The Relationship of the Urea Clearance to the Renal Blood Flow, Am. J. Physiol. *110*:387, 1934.

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1. Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

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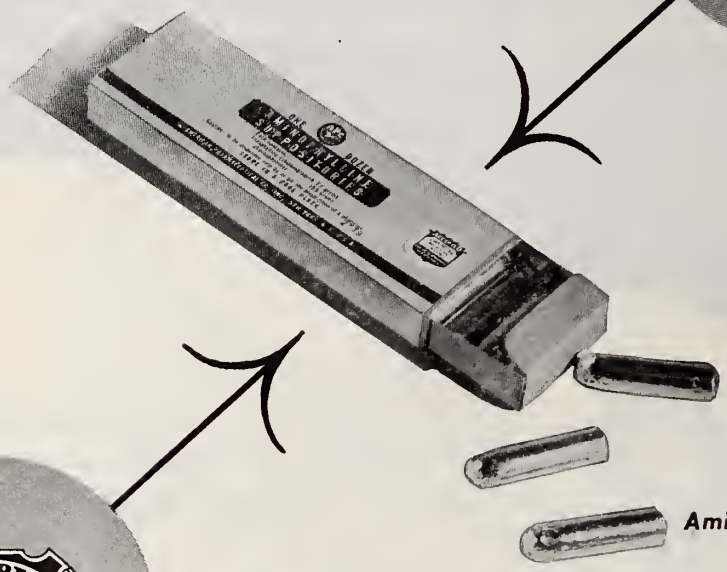
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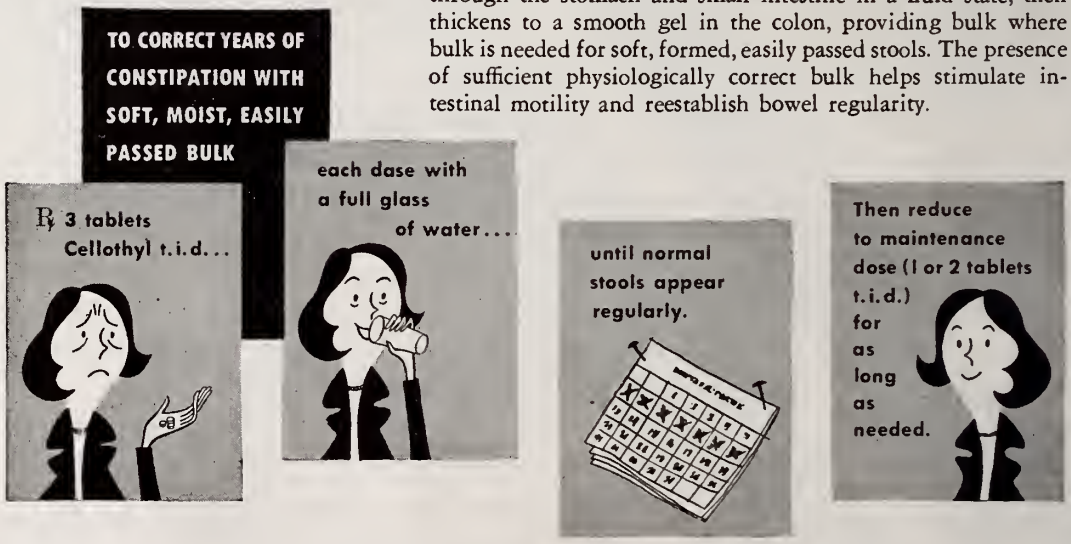
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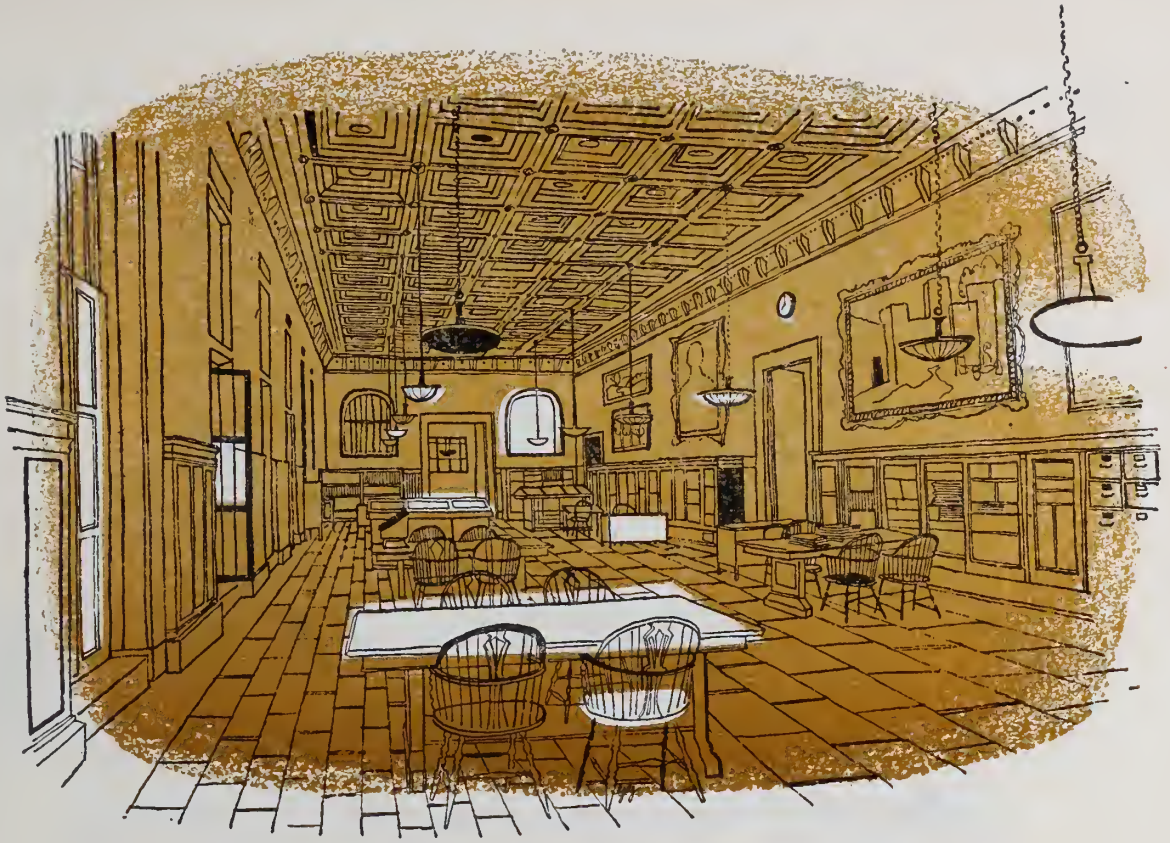
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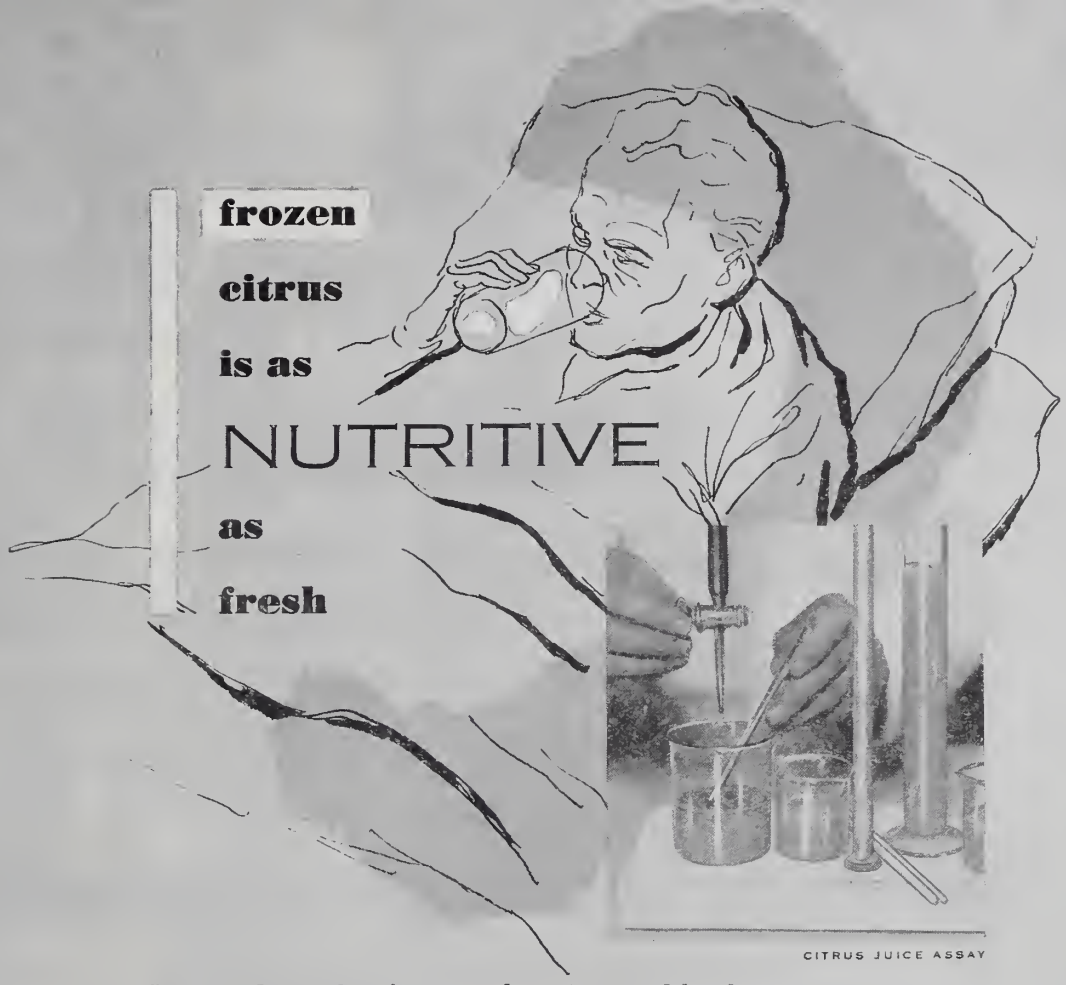
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**J.A.M.A. 146:35, 1951.*

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* Hamblen, E. C.: Some Aspects of Sex Endocrinology in General Practice, North Carolina M. J. 7:533 (Oct.) 1946.

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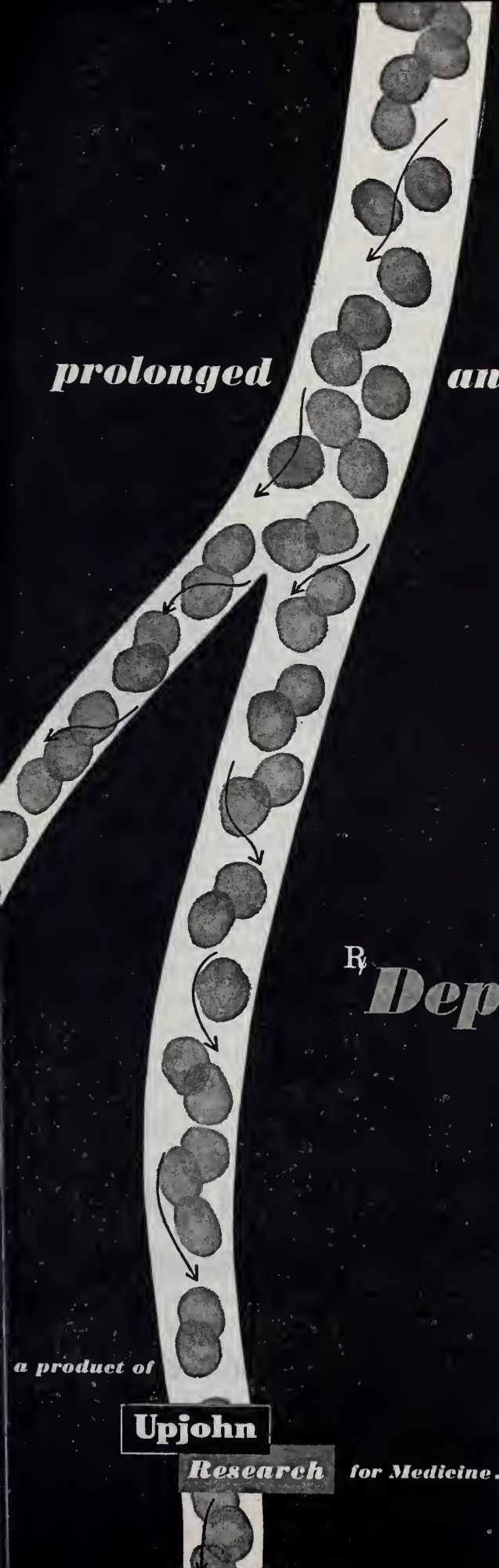
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1. Moss, Henry N., and D'Alessandro, Domenic R.: The intensity and duration of the effect of Depo-Heparin on venous coagulation time in man. Am. Practitioner & Dig. of Treatment 2:309 (April) 1951

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1 Crowe, S. J., etc. al., Penicillin & Tyrothricin in Otolaryngology Based on a Bacteriological and Clinical Study of 118 Patients, Ann. Otol., Rhinol. & Laryngol. 52:541, 1943.

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PRESIDENT'S MESSAGE

The prolonged controversy on the socialization of medicine has resulted in a drawing together of the various professions. A threat to one profession is a threat to all. While we have always maintained the closest relations with the pharmacists, the nurses organizations, and the New Jersey Hospital Association, we have not had such relations with the Dental and Bar Associations.

Recently a liaison committee has been formed between The Medical Society of New Jersey and the New Jersey State Dental Society. One of the purposes of this committee is to achieve cooperation in the solving of mutual problems. The first matter which came before this committee was jointly to conduct an educational campaign in favor of the establishment of a Medical and Dental School in New Jersey. The splendid spirit of cooperation evinced thus far has brought our two professions closer together, and it is our hope that many of our mutual problems can be jointly solved by our two professions uniting together in this way.

A still more recent development has been the formation of a liaison committee between The Medical Society of New Jersey and the New Jersey State Bar Association. One of the very best and most comprehensive analyses of the Wagner-Murray-Dingell Bill was made last year by the New Jersey State Bar Association. We are hoping that this new committee will accomplish a great deal of good for our respective organizations.

This new approach is an attempt to carry on our work beyond the confines of our own county and state medical

societies. One of the difficulties that we have experienced is to put into active practice the principles and policies which have been evolved and finally approved by the Board of Trustees and the House of Delegates. Too often after we have promulgated resolutions and forwarded them to the various organizations concerned, they are lost sight of and we can do little or nothing to carry on thereafter.

We hope through these further steps to advance to a more satisfactory conclusion the many projects which are initiated in our various committees. However, it is well to remember that time is one of the essential elements in the education of our own members as well as of other people, and the passage of many years is often necessary before we can see our plans develop into realities.

Sigurd W. Johnsen, M.D.

MEDICINE AND MORTALITY

Medicine enters 1952 with justifiable pride in an astonishing record of reduced disease mortality and prolongation of human life. A recent quarter-century summary* shows, for example, a decline in over-all mortality amounting to 55 per cent for females and 42 per cent for males. Nor is this exclusively the result of improved infant and child health technics. In the 65 to 74 age bracket, the mortality tumbled 25 per cent for males and 37 per cent for females. And when it comes to communicable diseases, the record is even more amazing. For instance, the death rate from communicable diseases in childhood has, in one quarter of a century, taken a 97 per cent fall! Even the "degenerative" disease category has shared in the falling death rate at all ages.

This makes us face 1952 with good heart and no little pride. But before we pat ourselves on our collective backs, it might be well to salute the many other workers in the health professions who have contributed to this gratifying record. Research scientists and dietitians, pharmacologists and surgeons, nurses and electronic engineers, public health officers and soil chemists, veterinarians and medical clinicians have all had a share in it. Much of the trail-blazing work in pharmacology and pharmacognosy has been done by the extra-ordinary American drug industry. Government too has helped, with money, protective legislation, clinical material and brain-power. It seems like a long distance from the test-tube and the guinea pig to the recovery of a dying child, but the connection is there. The magnificent progress of medicine is no idle boast, no empty propaganda, but rather a solid achievement translated into the fact that hundreds of thousands of citizens of all ages are alive now who would have been dead long since, were it not for modern medicine.

It looks as if 1952 is going to be a tough year in world politics and world economics. We doctors don't know much about either subject. And we suspect that the politicians and economists don't either. But in our own field—individual human health—we look forward to one more round of steady progress. May it be a happy new year to all the troops in our war against disease, death and injury!

*_Statistical Bulletin_ of the Metropolitan Life Insurance Company, 32:3 (September 1951).

ORIGINAL ARTICLES

SOME CRITERIA FOR SOCIAL MATURITY*

Crawford N. Baganz, M. D., Lyons, N. J.

In 1947, Brook Chisholm made the cogent observation that "never in the history of the world have there been enough mature people in the right places". This comment led many of us to re-examine our concepts of the nature of "maturity". In times of stress and strife, the need for mature people is obvious and paramount. All of us have observed that need in medicine, in the nation and in the world community. Another aspect of the need for socially mature people was highlighted by recent publicity with reference to physicians who had received their entire medical training at government expense but who somehow felt no obligation to serve their country in an hour of national need. It suggested that perhaps the minds of these young people had not reached the point where they could consider the wants and needs of others. Overstreet in his book *The Mature Mind* has expressed this very aptly. He writes that: "Immature life is life in which imagination has not yet stretched to take in the wants and needs of other people." Carl Binger likes to describe maturity as a continuing process rather than as a stage of maturity. "Maturity" he says "consists of giving, caring and protecting". In another place he defines maturity as the capacity to learn from the past without suffering from it.

I should like to offer this definition: social maturity is an insight and understanding of the responsibilities of the individual to his community combined with a desire to discharge this responsibility in a non-pathological manner. It appears further that this degree of social maturity is directly related to the size of the community to which the individual has this insight and understanding. The community may be the home, the neighborhood, the city, the county, the state, the nation or the people of the world.

The contributions of Freud to the field of psychosexual development, the recognition of the stages of auto-erotism, homo-erotism and hetero-erotism have been almost universally accepted and widely appreciated. Hetero-erotism (or hetero-sexuality) has been defined as the ability to select an individual of the opposite sex for a love object; the ability to create offspring and to have an emotional attachment toward these offspring.

The work on birth trauma by Otto Rank and the recent presentation (at the American Psychiatric Association) of radiographs of intra-uterine postures of the fetus are evidences of additional studies of the emotional growth of the individual prior to birth. That astounding scientist from "Astounding Science Fiction" —L. Ron Hubbard, more widely known as the author of *Dianetics* now tells us that engrams may occur at any time after fertilization of the ovum. Perhaps in the future the emotional status and psychologic condition of parents, as well as the pre-coital glint may be the subject of further discussion. This is but a small portion of the evidence of the mass of attention which has been paid to emotional development from intra-uterine life through adolescence.

Little attention has been directed, until recently, toward those degrees of development beyond the stage where an individual has a member of the opposite sex as a love object and has the ability to create offspring and have an emotional attachment toward them.

For some time it has been felt that the concept of hetero-erotism or hetero-sexuality has not been sufficient to describe the ultimate stage of maturity and development. As an evidence of this, the term "allo-erotism" has

*Dr. Baganz is Manager of the Veterans Hospital at Lyons, N. J. This paper was his presidential address, delivered to the New Jersey NeuroPsychiatric Association in Newark on December 19, 1951. The article has been reviewed by the Veterans Administration and is published with the approval of the Chief Medical Director. The statements and conclusions of the author do not necessarily reflect the opinion or policy of the Veterans Administration.

found increasing acceptance and usefulness. *Allo-erotism* may be defined as the expressing of the direction of flow of libido away from the subject and toward objects. The objectivation of libido takes the name "allo-erotism" and is the equivalent of Jung's extraversion, save that Jung denies the more or less exclusively sexual connotation of the process.

Jones defines allo-erotism as "erotism in connection with the idea of another human being".

The further need and wider understanding and utilization for this concept was recently demonstrated by Binger when he asked us to consider an eighteen-month old baby and to convert his body, in a 30-day period, to that of a six foot, 190 pound football player. Then we would have an individual with an eighteen month old intellect and emotion, but with a giant's physical prowess. He would probably tear his mother's clothes off, throw her downstairs and wreck the furniture. Truly—a physical menace. Take this same eighteen month old baby and in thirty days convert him to a six foot, 190 pound football player who has just been graduated from the Harvard School of Business Administration but who retained his eighteen month old infant's degree of emotional and social maturity. We would find an efficient functioning machine but while the previous monster was a physical menace, this new individual with the high I.Q. is a far greater social menace.

We have legal standards of age for the ability to make a contract; to enter into marriage and to enter military service. Our legal restrictions on maturity go no further than to specify minimum chronologic ages and to eliminate the psychotic and the grossly mental defective individual. Perhaps, the greatest menace is an individual with a high degree of intellect and a good physique who has progressed no further than the desire to secure an individual of the opposite sex as a love object and to satisfy his own desires without regard to the needs of others. His failure to recognize his responsibilities to the community, if placed in a position of authority, could cause not only a great personal loss but could wreck the lives of many others. Because of their aggressiveness, high intelligence and tendency toward unethical conduct they are not infrequently found in positions of high authority and responsibility. Perhaps the recent leader of the Nazi movement in Germany, Adolph Hitler, is a good example of an individual placed in a position of high authority who failed to recognize his responsibility to the community and the human wants and needs of others.

Let us go beyond the concept of hetero-sexuality and add another stage of development, which we may label "social maturity". Perhaps this can be structured at some point between the attainment of hetero-sexuality and complete social maturity. Thus, we can set up criteria by which we can measure individual cases. If you will accept the concept that an individual is mature (at least to some extent) when he recognizes his debt to his community, large or small, and has a true non-pathological desire to pay off this debt, then we can assess individuals to determine how far they have progressed toward this stage. At this point one word of caution should be voiced: this desire to be of community service should *not* be symptomatic of a psychiatric disorder. Is this anxiety to make a contribution a selfish desire to erect a personal monument — the Jane Doe Hospital for Women or the John Smith Home for Wayward Children? Does this desire to make a contribution arise out of persecution or intolerance? Is this desire to make a contribution a socially determined discrimination arising out of unusual needs or used to bolster a failing repression? Is this desire to make this community contribution based upon aberrant thinking such as that of the food faddists or that exhibited by a character in a nearby community who is thoroughly convinced that mankind's ills arise from the use of tobacco, chocolate and cola drinks? In order to further his concept, he takes cigars and cigarettes from the mouths of smokers, upsets soda drinks at fountains and takes chocolate candy away from children.

If we can rule out these desires to make contributions because of abnormal or pathologic needs, then we can judge certain individuals, according to the criteria of their abil-

ity to recognize their community responsibilities and their desire to make community contributions.

May I offer for your consideration the following cases:

CASE ONE

We had a physician on our staff some time ago, who was asked to accept a temporary assignment at another Veterans Hospital at some distance. He was assured of transportation, expenses and his return to this hospital after a period of 30 days. He was unmarried, had no pressing responsibilities, and was offered this opportunity to serve for a short period of time until his replacement could report. On being presented with this opportunity his reaction was "What's in it for me?".

CASE TWO

We have all heard of the doctor (though none of us know him) who, when called in the middle of the night to care for a sick child replies not "What's wrong with the baby" but "My fee is $7.00 —have you got the money?".

CASE THREE

Where would you place the present social maturity of 4000 ASTP and V-12 trained physicians of whom, prior to the present draft act, *only one* volunteered for military service?

CASE FOUR

I invite your appraisal of the physician, who says, "Doctor, I have a great deal of compassion for chronic psychotic patients; I feel there is much that can be done with them; but I am thoroughly unable to understand them and feel helpless in caring for them. I want to quit and go to a fresh water college and do student health work (at greatly reduced income)."

CASE FIVE

What about the social maturity of the country physician who answers the continuing and often unreasonable demands of his community, who is forced to forego the advantages of medical meetings, who sacrifices his health and frequently his life, for the benefit of his community and who furthermore sees many of his patients go to the large city specialists when they really become interesting subjects?

CASE SIX

What is the degree of social maturity of the relatively uneducated coal miner who, in a community of first generation Americans, has succeeded in raising a family of eight children, and, in addition to this, has developed a tolerance towards the aged, the infirm, the mentally defective and the morally deficient persons in his community? Because of the development of this tolerance, this relatively uneducated coal miner attempts to do something for these less fortunate people.

I have given you these six examples to illustrate the method by which these suggested criteria for social maturity may be applied. It is possible that this concept may contribute something to a better understanding—not only of our patients but of our leaders in medicine, our national leaders and our leaders in world communities. Recent television performances of the deliberations of the United Nations at Lake Success also give us repeated opportunities to apply these criteria to people in top diplomatic positions who may well influence not only the liberty but the life of this and following generations.

These criteria for social maturity are not new. Many have known them for centuries. Socrates advanced them centuries ago. They were considered so unacceptable that he was tagged with "the famous hemlock highball".

The famous 13th Chapter of St. Paul's First Letter to the Corinthians expresses these concepts far better than I shall ever be able to do:

1. If I speak with the tongues of men and of angels, and have not charity, I am become as sounding brass, or a tinkling cymbal.
2. And if I should have prophecy and should know all mysteries and all knowledge, and if I should have all faith, so that I could remove mountains, and have not charity, I am nothing.
3. And if I should distribute all my goods to feed the poor, and if I should deliver my body to be burned, and have not charity, it profiteth me nothing.
4. Charity is patient, is kind; charity envieth not, dealeth not perversely, is not puffed up;
5. Is not ambitious, seeketh not her own, is not provoked to anger, thinketh no evil;
6. Rejoiceth not in iniquity, but rejoiceth with the truth;
7. Beareth all things, believeth all things, hopeth all things, endureth all things.
8. Charity never falleth away: whether prophecies shall be made void or tongues shall cease or knowledge *shall be* destroyed.
9. For we know in part: and we prophesy in part.
10. But when that which is perfect is come, that which is in part shall be done away.
11. When I was a child, I spoke as a child, I understood as a child, I thought as a child. But, when I became a man, I put away the things of a child.
12. We see now through a glass in a dark manner: but then face to face. Now I know in part: but then I shall know even as I am known.
13. And now there remain faith, hope and charity, these three: but the greatest of these is charity.

SLIPPED FEMORAL EPIPHYSIS

Robert E. Humphries, M.D., East Orange, N. J.

Slipping of the femoral epiphysis is a rare condition affecting 'teen age children in which the head of the femur is displaced from the neck. It is really not a "slipping" of the head from the neck but an evulsion of the head from the neck of the femur. The head of the femur becomes frozen to the acetabulum by a deposit of calcium in exactly the same way that the shoulder becomes frozen in bursitis. This deposit is caused by a rheumatoid process. Any motion of the thigh throws a great strain on the epiphyseal line of the femur which ultimately gives way allowing the head to shift its position over the neck. If treatment is not instituted at once the head shifts further and further until it is ultimately completely displaced. This will also happen if any violent motion of the femur occurs.

In the early stages, the patient complains of pain (usually referred to the knee) and of walking with a limp. This pain in the knee may be confusing to anyone not familiar with hip pains. Examination at this time will reveal that the hip is held in slight flexion and internal rotation. Motion in the hip joint is limited by pain and spasm. On further examination it will be found that there is also pain and limitation of motion in other joints. This factor distinguishes it from other hip joint conditions. Children suffering from this condition are usually overweight. More girls than boys are affected.

During the past fifteen years, seven of these cases have come under my private care. Six of them were girls. These children were all overweight. They had pain and spasm in all of their joints. Four complained of pain in the left hip and three in the right hip. The hip in each case was held in slight flexion and internal rotation. No free motion was allowed from this position, forced motion caused pain and spasm. No patient had more than 3/16 of an inch displacement of the head from the neck. All but two of these patients were treated conservatively. Weight bearing was not discontinued. All recovered without perceptible shortening of the leg and with complete motion in their hip joints. Two of the cases are reported below in more detail.

The factor underlying this condition is the deposit of calcium in the acetabulum. It is essential to remove that factor if permanent results are to be expected. A surgical operation may prevent further slipping of the femoral head, but it has two disadvantages. First, it may destroy the epiphysis (causing shortening of the leg); second, it fails to decalcify the acetabulum. Decalcification is essentially a matter of regulating the diet. One aim is to reduce weight; another is to alter the calcium metabolism so as to reduce the deposit of that element in the joints. Most of these patients like to eat between meals. My experience is that if the doctor places them on a suitable decalcifying diet, and rigidly bans eating between meals, he will accomplish good results. I think it is important to keep the bowels open and for that purpose prescribe a cascara sagrada laxative.

If the epiphysis has been loosened, it will be about six months before this has corrected itself. In the meantime, patients should be cautioned about climbing stairs, jumping, bicycle riding, or other forms of exercise which might strain a weakened epiphysis.

CASE ONE

An eleven year old girl came to me complaining of pain in her left hip. She had been treated for a year with no relief. Her hip was now held rigidly at 170 degrees flexion and in slight adduction. There was no free motion in her hip joint. X-ray showed slipping of the epiphyseal of ⅛ of an inch with irregularity of the epiphyseal line. She also had pain in other joints and was much overweight. She was put on a limited diet of three meals a day; nothing between meals and ordered to take 5 grains of cascara daily. In one week she had gained considerable motion in her hip. Unfortunately on her way home from the office she slipped on the ice and completely displaced the head from the neck. She was taken to a hospital and the fracture was reduced by the Leadbetter method. Plaster was applied from toes to ribs. In eight weeks plaster was removed and she was

allowed up on crutches. Two weeks later she was allowed full weight bearing. She has had no further trouble and there is no shortening of her leg.

CASE TWO

A 19 year old boy came to me giving the following history: Four years previously he had suffered from a slipped epiphysis. He was treated by an orthopedist who had admitted him to the hospital and inserted a Smith-Peterson nail which was subsequently removed. He had not been relieved of his pain and walked with a limp. On examination his right leg was found to be an inch shorter than the left. There was marked limitation of motion with pain and spasm in his right hip. He was put on a limited diet of three meals a day and given sodium sulphate daily. In four weeks he was entirely free from pain and had nearly normal function in his hip. Of course, he will always limp because his right leg is shorter. But the pain and discomfort are gone.

637 Central Avenue

TERRAMYCIN* IN INFECTIOUS ASTHMA

A PRELIMINARY REPORT

FRANK L. ROSEN, M.D., Newark, N. J.

Twenty patients with bronchial asthma were chosen for this study. Their attacks usually followed an upper respiratory infection; or the attack of asthma appeared concurrently with the upper respiratory infection. All were office patients treated in the routine practice of allergy. The group included five children. Their ages ranged from three years to sixty years. The duration of bronchial asthma varied from one year to twenty-five years. All patients were symptom-free and "negative" to physical examination in between asthma attacks.

Only three of the twenty had upper respiratory infections as the sole cause of their asthma attacks. In addition, attacks would result in the other seventeen from atopic factors, weather changes, emotional tension and physical exertion.

One dozen 250 milligram Terramycin* capsules were given to each patient, with instructions to take two capsules on the onset of asthma, and then one capsule three times a day with about one-fourth of a glass of milk immediately after each capsule.

Of the twenty patients, thirteen were relieved of the attack within forty-eight hours, a few within twenty-four hours. Most of these patients had noted that attacks previously would last four to seven days. Three patients were relieved of their attacks within four days. In this group, therapy is difficult to evaluate. Four patients received no benefit from Terramycin.*

Diarrhea occurred in four of these twenty patients. One was severe, accompanied by nausea and vomiting. Two were of moderate severity. In the other case, the diarrhea was mild.

It is concluded that Terramycin* is a valuable medication in the treatment of infectious asthma.

This is a preliminary report on a project which will be published in more detail in a national allergy periodical.

* Charles Pfizer and Company, Brooklyn 6, N. Y., were the manufacturers of the Terramycin. This study was made possible through the cooperation of Dr. W. A. Wright, Director of Medical Service for that company.

32 Johnson Avenue

INJECTABLE KHELLIN IN THE ANGINAL SYNDROME

SAMUEL H. SCHWARTZ, M.D., and JULIUS MINTZ, M.D., Plainfield, N. J.

The plant *Ammi Visnaga,* known in Arabic as "Khella", grows wild in the Eastern Mediterranean countries. Decoctions of its seeds have been used as an antispasmodic since ancient times. From these seeds three crystalline substances have been extracted in pure form: khellin, visnagin and khellol-glucoside. Visnagin has biologic action similar to khellin but it is about 30 per cent weaker. Khellol-glucoside is present in large amounts but is not absorbed from the gastro-intestinal tract, nor does it have any biologic action. This leaves khellin as the only practical substance at the present time.

The pharmacologic action of khellin has been thoroughly studied by Anrep[1] and his co-workers. Khellin causes relaxation of all the visceral smooth muscles. It produces a conspicuous dilatation of the coronary blood vessels. There was definite coronary vasodilation in the heart-lung preparation of dogs with a concentration of 10^{-6}, and coronary sinus outflow increased up to threefold with a concentration of 10^{-5}. This action was much more prolonged than that produced by amyl nitrate although somewhat less in intensity. Gradual administration of khellin up to concentrations of 10^{-4} had no undesirable effect on the heart muscle, respiration, or general blood pressure. In addition, khellin relaxed the bronchial musculature of the guinea pig after histamine induced spasm, and also produced intestinal relaxation in the whole animal. Although khellin will dilate the peripheral vessels, this required concentrations far beyond the therapeutic dose, thus making its action on the coronary vessels specific. When compared with aminophyllin, results on the heart-lung preparations and on the isolated rabbit heart showed the effect of khellin upon the coronary blood flow to be about four times stronger in therapeutic concentrations.

Administered intramuscularly, khellin is rapidly absorbed into the circulating blood stream, reaching a maximal concentration in 5 to 7 minutes. Orally it is rapidly absorbed from the gastro-intestinal tract reaching a maximal concentration in the blood in 10 to 15 minutes. After absorption it becomes almost uniformly distributed in all the tissues and organs of the body. Its destruction and excretion is slow, the concentration in the tissues being halved in 24 hours. Traces are still present in the blood and tissues as late as four days after administration. Anrep[1] also reported the effect on the electrocardiogram thirty minutes after the intramuscular administration of 100 milligrams of khellin. In their series, electrocardiograms were taken before and after exercise for evidence of coronary insufficiency. In all of their cases RS-T depression and T wave inversion were prevented by the drug.

Best and Coe[2] studied the effect of khellin on the electrocardiographic pattern in patients with coronary insufficiency after oral administration of 150 milligrams daily for 2 to 4 weeks. The stress tests used were Masters exercise tolerance test, the anoxemia test of Levy and the ergonovine test of Stein. In nine patients, fourteen of twenty-five pretreatment tests were positive. Ten of the fourteen tests (71.4 per cent) became negative after khellin therapy. All tests reverted to pretreatment status with placebo therapy. The authors concluded that the conversion to a normal pattern of 71.4 per cent of previous abnormal EKG tests of coronary insufficiency would indicate that the drug is helpful in preventing myocardial anoxia.

Scott *et al.*[3] on the other hand, with a modified two step test found only two out of eleven patients who showed even questionable improvement after oral khellin. One of five patients given intramuscular khellin showed less marked S-T segment depression after exercise

1. Anrep, G. V., Barsoum, G. S., Kenawy, M. R., and Misrahy, G: British Heart J., 8:171 (1946); *also* Anrep, G. V., Kenawy, M. R., and Barsoum, G. S.: Am Heart J. 37:531 (1949); *and* Anrep, G. V., Barsoum, G. S., and Kenawy, M. R.: J. Pharm. and Pharmacol., 1:164 (1949).
2. Best, Maurice M., and Coe, Walter S.: Circulation, 2:344 (1950).
3. Scott, R. C., Inglaner, A., Green, R. S., Kaufman, J. W., Berman, B., and McGuire, J.: Circulation, 3:80 (1951).

than he had shown following control tests. There was increase in cardiac output following intramuscular injection in only one of eight patients as measured by the ballistocardiograph.

Clinical evaluations of khellin in the treatment of the anginal syndrome have appeared in the literature. Anrep and his associates[1] reported results on two hundred and fifty cases. Dosages used ranged from 150 to 300 milligrams daily orally. Some patients received intramuscular injections of 100 milligrams once or twice daily during the acute attacks, and seven received a combination of oral and injectable therapy. One hundred and forty (56 per cent) of the patients showed good improvement. Eighty-five (34 per cent) showed moderate improvement, while twenty-five (10 per cent) reported no improvement. Side actions were minimal and included: (1) A sensation of warmth in some patients; (2) mild "dyspeptic" symptoms in a few patients; and (3) insomnia in a few patients. Rosenman *et al.*[4] reported two different series. Dosage was 150 milligrams a day with placebo tablets as a control. Their criteria for improvement were: (1) decrease in number and severity of attacks; (2) increased exercise capacity; (3) increase in general well-being. In their first series of fourteen cases there was definite improvement in eleven, moderate improvement in one, and no benefit in two patients. Side reactions were reported in five of the fourteen patients: nausea in three cases and insomnia in two. The drug had to be discontinued in only one patient. In an additional series of sixteen patients there was definite improvement in six cases and moderate improvement in two cases. In the remainder, evaluation was not possible largely because of the side reactions which appeared in eleven of the sixteen. These complications were severe enough in nine to prevent continuation of the drug. The side reactions were: (1) nausea in seven cases; (2) vomiting in one case; (3) constipation in three cases; (4) diarrhea in four cases; (5) dizziness in four cases; (6) somnolence in one case; (7) vesiculopapular eruption with pruritis in one case; and (8) urticaria in one case. Rosenman and his associates[4] concluded that khellin was of definite value in relieving many patients with angina pectoris, the results often being dramatic, especially in patients with severe angina. The clinical value, however, was limited by the high incidence of unpleasant side reactions. Armbrust and Levine[5] reported on fifty-three patients. Dosage was 40 milligrams three times daily after meals and placebos were used as a control. Using the criteria of (1) fewer and milder attacks of pain; (2) ability to walk greater distances; and (3) necessity for less nitroglycerine, they reported improvement in 60 per cent of their patients. Side reactions occurred in more than half of their patients. These included nausea, anorexia, and dizziness. Best and Coe[2] in recording the symptomatic response in their nine cases, stated that seven patients noted increase in exercise tolerance and decrease in the number and severity of anginal attacks on khellin therapy but not with the placebos. One patient experienced improvement with both khellin and placebos and one patient had no subjective improvement. Toxic symptoms consisting of nausea and vomiting occurred in only three of the patients but were not severe enough to limit use of the drug. Greiner, Gold *et al.*[6] reporting on 39 patients observed under both khellin and placebo therapy could find no difference in the two in controlling the pain of the angina of effort. The dosage of khellin, however, ranged between 50 and 150 milligrams a day. Thirteen (33 per cent) of the patients had unpleasant symptoms which could be attributed to khellin. Of these, two refused to continue the drug because of vertigo, drowsiness, unrest, and impaired power of concentration. The drug had to be discontinued in two others because of anorexia, nausea, vomiting, and epigastric pain which persisted even with reduced dosage. The remaining nine had milder discomfort referable to the gastro-intestinal or central nervous system. The unpleasant reactions occurred with the larger dosage. In the series reported by Scott and associates,[3] four of twenty patients experienced fewer anginal attacks while receiving oral khellin. Eleven

4. Rosenman, R. H., Fishman, A. P., Kaplan, S. R., Levin, H. G., and Katz, L. N.: J.A.M.A., 143:160 (1950).
5. Armbrust, C. A., Jr., and Levine, S. A.: Am. Jr. of Med. Science, 220:127 (1950).
6. Greiner, T., Gold, H., Cattell, M., Travell, J., Bakst, H., Rinzler, S. H., Benjamin, Z. H., Warshaw, L. J., Bobb, A. L., Kwit, N. T., Modell, W., Rothendler, H. H., Messeloff, C. R., and Kramer, M. L.: Am. J. of Med., 9:143 (1950).

others stated that their pain was less severe and that they were able to do more work. Seventeen of the twenty patients experienced one or more undesirable reactions, the most frequent being nausea, anorexia, epigastric burning, dizziness, and diuresis. Other side reactions attributable to the drug were pyrosis, abdominal cramps, gaseous distention, diarrhea, constipation, weakness, "smothering", numbness in arms and legs, "sick all over", insomnia, and drowsiness. The authors, attempting to evaluate the discrepancies of other reports believed that the most apparent reason was the difference in dosage. They felt that the dose should be increased even up to 240 milligrams per day (300 milligrams under the old assay) if tolerance permitted. The unpleasant side reactions, however, prevent many patients from taking enough khellin to achieve benefit.

Our experience with oral khellin has confirmed this. A high proportion of our patients with the anginal syndrome are benefitted by the drug as manifested by fewer and milder attacks and increase in activity if they can tolerate 120 milligrams or more of the drug daily. Unfortunately most of our patients have been unable to take such doses. Since the majority of toxic symptoms are referable to the gastro-intestinal tract, we used parenteral khellin in two of our severest cases to determine whether this route of administration was practical, whether it would benefit our patients, and whether side reactions could be reduced.

The material used in our cases was an aqueous suspension of khellin containing 50 milligrams of the drug[8] per cubic centimeter. Two cubic centimeters are given by deep intramuscular injection in the gluteal region daily for ten days. The patients were examined by one of us daily. Systemic as well as local reactions were looked for and the symptomatic effect was ascertained. No attempt was made to suggest improvement to the patients and only their spontaneous comments were recorded.

CASE REPORTS

A 48 year old white laborer was originally hospitalized in 1947 for a coronary occlusion, with anterior myocardial infarction. He made an uneventful recovery and subsequently returned to his work which he continued until December 1950. At this time he again experienced severe precordial pain which required one-half grain of morphine for relief. An electrocardiogram two days later showed no evidence of recent myocardial infarction and the patient was made ambulatory. Any effort on his part, however, resulted in severe anginal pain. Nitroglycerine gave relief for a short time only. In January 1951, he began taking khellin by mouth, 120 milligrams a day in divided doses. After three days he exhibited marked relief but on the fourth day he developed nausea, vomiting, and diarrhea and the drug had to be stopped. Resumption of therapy several days later with 80 milligrams per day again produced toxic symptoms which necessitated discontinuance of the drug. On March 20, 1951, he first received parenteral khellin,[8] 100 milligrams (2 cubic centimeters) intramuscularly daily for ten days. On the third day the patient asked whether it would be all right for him to resume his occupation. He had not had pain for the past 24 hours nor did he exhibit any more pain during the remaining seven days of treatment. Following this he was placed on 40 milligrams of khellin orally daily which he has now continued for about two months. He has returned to work and has been comfortable up to the time of this report. He does have mild episodes of pain occasionally but these are of short duration and do not interfere with his activity.

A 56 year old housewife was hospitalized in April 1949 for a coronary occlusion with anterior myocardial infarction. Following a stormy period of ten days, initially she had an uneventful course and was discharged from the hospital on June 12, 1949. In January 1950 she developed congestive heart failure which was controlled by the usual methods. In February 1950 she again had precordial pain and was hospitalized in another city. Study there revealed no new infarction and the usual therapy for angina was instituted without relief. She was finally controlled with small doses of Pantopon[7] and was sent home. She soon developed pain at rest as well as on exertion to the point where she became bedridden. Her Pantopon[7] requirements gradually increased so that she eventually needed two grains daily to remain comfortable. In March 1950 she received 40 milligrams of khellin three times daily and by the fifth day exhibited marked improvement. On that day she required only one injection of a third of a grain of Pantopon.[7] By the end of a week she could get out of bed for most of the day. On the tenth day, however, she developed a severe diarrhea followed by nausea and vomiting and the drug had to be stopped. Several days later it was resumed at a dose of 40 milligrams twice a day but toxic manifestations returned. The drug was discontinued for two more days and she was then placed on one tablet (40 milligrams) daily. Her Pantopon[7] requirements

7. Pantopon is a mixture of the soluble hydrochloride salts of the total alkaloids of opium. The word *Pantopon* is registered by Hoffmann-La Roche, Inc.

8. Ammivin is the registered trademark of a brand of crystalline khellin prepared by the National Drug Company of Philadelphia. This company kindly furnished the supply of intramuscularly injectable Ammivin for this project.

again gradually rose and after a month she was again practically bedridden and was taking between one and two grains of Pantopon[7] daily. On March 17, 1951, she received khellin[8] intramuscularly, 100 milligrams being given deep in the gluteal region daily for 10 days. By the fourth day she "felt like a new person" and resumed a certain amount of activity. After seven days she stopped the Pantopon[7] entirely. Following the course of parenteral khellin she was continued on 40 milligrams of the drug orally. This has kept her reasonably comfortable for two months. She occasionally requires small doses of Pantopon,[7] one sixth to one third of a grain but the overall improvement has been dramatic.

Neither of these patients exhibited toxic manifestations while on intramuscular khellin. There was slight "stinging" at the time of injection and the local reaction was comparable to that obtained with aqueous suspensions of procaine penicillin.

Despite conflicting reports there is enough evidence that many patients with angina pectoris are benefitted by khellin if they can tolerate adequate doses. Unfortunately the drug has many undesirable side reactions, most of them referable to the gastro-intestinal tract. To avoid these reactions, we used the parenteral route to build up an adequate concentration and then changed to a small dose, by mouth. Our two patients exhibited a dramatic response with this method.

SUMMARY

1. The pharmacologic action, the clinical effects, and the toxic manifestations of khellin are reviewed.

2. Two cases are presented in which the patients could not tolerate adequate doses of oral khellin but who showed dramatic results when the drug[8] was administered intramuscularly.

121 East Seventh Street

FIRST INTERNATIONAL PHARMACOPOEIA

For the first time in world history an international pharmacopoeia setting uniform standards for major drugs is now available. The book was recently published by the World Health Organization upon the recommendation of its 79 member states. It contains descriptions of 200 important drugs and is expected to bring uniformity in standards for drugs in international use. The volume also contains numerous appendices including instructions for establishing purity and strength of drugs. The drug names are given in Latin. The text is available in either English, French or Spanish editions. For further information on how to obtain a copy write to the Pan American Sanitary Bureau, 1501 New Hampshire Avenue, N. W., Washington 6, D. C.

OBSTETRICAL-GYNECOLOGY CONGRESS

The American Congress on Obstetrics and Gynecology will meet in Cincinnati, Ohio, March 31, through April 4, at the Netherland Plaza Hotel. This session will feature a comprehensive five-day scientific program covering all aspects of the maternal care team.

Meetings will be devoted to dystocia, sterility, urinary incontinence, uterine carcinoma, obstetric hemorrhage, ovarian tumors, toxemias, and fetal wastage. Panels will consider complications of puerperium, Rh and Hr sensitization, maternal mortality, lesions of the vulva, endometriosis, pregnancy complicating medical conditions, uterine bleeding, and cesarean section. Discussions will follow each presentation. Arrangements have been made for submittal of written questions by mail or at the Congress.

Highlight of the public health program will be an initial report on the results of a new study of 10,000 neonatal deaths by the Chicago Health Department. An afternoon program will analyze the causes of the infants' deaths and recommendations on how these could be reduced further.

Congress registration fees are $5. for members and $10. for non-members. Further information, registration or reservations can be obtained by writing to the Executive Secretary, American Committee on Maternal Welfare, 116 South Michigan, Chicago 3, Illinois.

APPLY FOR SPECIAL M.D. LICENSE PLATES

Members are reminded to apply for special M.D. license plates immediately. File application with the Director, Bureau of Motor Vehicles, State House Annex, Trenton 7, N. J.

INSULIN SUBCOMA THERAPY IN THE TREATMENT OF ANXIETY STATES *

A STUDY OF FIFTY CASES IN PRIVATE OFFICE PRACTICE

ROBERT VAN AMBERG, M.D., Montclair, N. J.

Insulin in subcoma doses played an important part in the treatment of "combat exhaustion" in the British and American armies in World War II. The first to report its use in these essentially "neurotic" states was a group of British physicians[1] caring for survivors of the battle of Dunkirk. In the same year, 1941, Sargent and Craske[2] outlined the use of "modified insulin therapy" in acute neuroses of war. Subsequently the Americans, following the British lead, widened insulin's usefulness, and had it playing an important part in the management of the acute neuroses in the European Theater.[3] My own experience with over twelve hundred American combat exhaustion patients receiving insulin in Britain, compared closely to that of other medical officers, and strongly indicated that we had an effective adjuvant in the treatment of certain acute anxiety states.

Following the war, insulin subcoma therapy in civilian neurotic anxiety states gained considerable acceptance. In the last five years, however, most published studies have continued to concern themselves with illnesses in a military setting.[3,4,5,6,7] There is general agreement that insulin has some beneficial effect, particularly upon recently developed cases, but that it is only an adjunct to other treatment measures.

This study is an analysis of the author's first fifty private practice patients to receive insulin therapy for anxiety states, as an office procedure.

Treated in the period from April 1946, to April 1950, these fifty cases represent 25 per cent of all the anxiety states under treatment at that time. It is my practice to treat anxiety states by weekly one-hour interviews, with or without light barbiturate sedation. This group of insulin-treated patients, however, was formed as a result of several compelling considerations. In six instances treatment was started after the first interview because the patient was in such desperate straits, and the family so distraught, that a choice had to be made between prompt hospitalization or some type of treatment that offered hope of swift relief in the near future. The other forty-four patients turned to insulin slowly, in the following manner.

During the first interview (after the patient had the nature of his illness explained) insulin therapy was mentioned casually to make known that an adjunct to the interview procedure was available. In this connection, I emphasized the "physiologic disturbance" aspect of the illness. It was noted that insulin therapy was rather expensive and might become a nuisance. The matter was not mentioned again, but the patients were exposed occasionally to others who were under treatment. When, after weeks and even a year of psychotherapy, the patient's condition proved to be discouragingly stationary, or became worse, insulin was once more introduced as a measure to be tried. All patients but one were actively, even eagerly, cooperative in the procedure after their apprehensions about the first treatment were dispelled by the treatment itself.

All subjects were private patients, referred by their family physicians. They had been receiving medical care for periods of several weeks to many years. All had had extensive laboratory investigations. Twenty-two had worked with other psychiatrists.

PROCEDURE

The technic of subcoma insulin administration has been repeatedly described.[2-9] However, a few modifications and some observations on the course of treatment deserve noting. Treatments were administered in an office suite, one patient to a room. Most patients were treated in the morning having fasted from the previous midnight. A few, however, received treatment either at noon-time or 2 p. m., having had a light meal four to five hours before treatment. These afternoon hypoglycemic reactions were thoroughly satisfactory.

Doses varied from 10 to 100 units intramuscularly, most patients receiving a dose between 20

* Read before the Annual Meeting of the American Psychiatric Association, Cincinnati, Ohio, May 7, 1951.

and 60 units. In a few instances a combination of intramuscular insulin followed by intravenous insulin was needed to start a reaction in one to one and a half hours.

By freely adjusting the insulin dose day by day, we sought a hypoglycemic reaction which produced a sense of drowsy relaxation for a period of 30 to 45 minutes. If palpitation, twitching or trembling became uncomfortable before that time, the treatment was terminated. It was noted repeatedly that the reaction could be carried to such a point that marked apprehension was induced. We made an effort to avoid such a response for the increased anxiety tended to last many hours, with an intensification of some of the patient's presenting symptoms. It has appeared to us lately that patients having treatment later in the day, after a light meal, have uniformly pleasanter and gentler reactions, with a more definite and more prolonged sedative effect, than those achieved in the fasting state.

A course of eighteen treatments, six a week, came to be our standard course, empirically. Most of our patients who responded well seemed to feel quite comfortable by the end of two and a half weeks. A few patients who responded slowly, with promise of additional benefit with more treatment, were given forty or more treatments.

In those instances in which depression appeared to be a prominent feature, a few electroshock treatments were administered in combination with insulin, usually toward the end of the course of treatment. Only a few treatments were needed as the depressive element tended to clear promptly. We found that with insulin hypoglycemia, electroshock did not have its anxiety-aggravating effect on several patients who had received electroshock alone at a previous time, to their great detriment.

ANALYSIS OF RESPONSES

Although all 50 patients had in common a diagnosis of "psychoneurosis: anxiety state"; with marked and predominant emotional reactions of anxiety and fear, the differences among them were numerous. Some responded to insulin in a dramatic manner, others did moderately well, and still others were completely unaffected. There were marked differences in the number of symptoms each suffered as well as in the degree of discomfort and disability experienced. Duration of illnesses varied from one to thirty years. The patients differed greatly as to personality traits and as to the number and timing of stress factors they had to cope with.

There being so many variables in the development and character of these illnesses, it was felt that some interesting relationships might come to light by studying our patients grouped according to their responses to insulin therapy.

Group one (eighteen patients, roughly one-third) were those who became symptom-free during, or very shortly after, the use of insulin.

Group two (seventeen patients) were those who showed a definite but incomplete response.

Group three (fifteen patients) were those who remained unaffected.

Comparing cases of anxiety states on the basis of symptomatology was extremely difficult in that some patients suffered as many as sixty or seventy symptoms at one time. To simplify matters, therefore, we grouped the symptoms under a few general headings. Some assumptions had to be made.

Tension: Under the heading of "Tension" are subsumed those symptoms which appear to stem from persistent skeletal muscle tension: tightness about the head, tightened or "stiff" neck, compression about the chest, low back pain, tendency to keep fists clenched, a general sense of tightness throughout the body, recurring blurring of vision, and tinnitis "when nervous", to mention only a few.

Depletion: Under the heading of "Depletion" are included: feeling of exhaustion, weakness, loss of initiative, loss of interest in matters formerly important to the patient, and tremulousness without excitement.

Over-excitation: In this category are: sensitiveness to noise and light, a state of general excitability, trembling, abdominal "butterflies", a tendency to over-activity, startle reaction, irritability on slight frustration, and palpitation. Insomnia seems to fit in well with this group.

No other symptoms are grouped with the subjective sensation of "Anxiety".

Under *phobias,* are all fear reactions caused by patients' exposure to specific situations or objects.

We use the word *panic* to indicate the beginning of disorganized behavior in which the patient is wracked by feelings of crisis or doom, suffering extremely alarming symptoms.

Under the heading *vascular disturbances* are: temporal headaches, light headedness (fainting feeling), fleeting areas of parathesias, cold hands and feet, and flushing.

The remaining categories of symptoms consist of: "gastro-intestinal disturbances"; "sexual disturbances"; "urinary disturbances"; "depression"; and "impairment of intellectual

powers" (reduced powers of concentration, grasp, recall, calculation, etc.)

Although the three groups were separated on the basis of their response to only one phase of their total treatment, there was a tendency toward homogeneity within each group.

The patients in Group I, being between twenty and fifty years of age, were slightly younger than those in the other two groups. There were no appreciable differences as to sex, marital status, religion, and type of occupation. The insulin-resistant Group III had somewhat less education than those in the other groups, about one half failing to go beyond second year high school. High school graduation at least was achieved by virtually all the patients in Groups I and II.

Most of the patients in the completely-responsive Group I had been concerned with functional and/or emotional disturbances for one to five years; almost all in the incompletely-responsive Group II had been troubled for three to twenty years; and all in Group III, for ten to thirty years, or a lifetime.

Previous episodes of incapacitation were suffered by one-half of Group I, two-thirds of Group II, and four-fifths of Group III. The current episodes had been present one to six months for most (eleven) in Group I, two months to one year for most (fourteen) in Group II, and one to three years for most (eleven) in Group III.

Viewed according to symptomatology, each of the three groups sharply contrasted with the other two. Group I appeared to be primarily a state of depletion, characterized by marked fatigue (all eighteen patients), tension (seventeen patients), over-excitation (fourteen patients), anxiety (fourteen patients), weight loss (eight to sixty pounds by twelve patients), and intellectual impairment (twelve patients). Panics (two instances), and phobias (four instances), were few in number, recent (less than one year in development), and quite incidental. Organ disturbances were not distressing, even seemed incidental in spite of a sharp decline in sexual interest and power and the presence of gastro-intestinal disturbances in almost all instances.

Group II patients suffered all classes of symptoms, to an intense degree. Anxiety was severe and almost continuous (sixteen cases). Most prominent were symptoms of over-excitation (all), panics (sixteen cases), and phobias (fourteen cases), overshadowing the still severe tension symptoms and disturbances of all organ systems, impaired intellectual function and depression (fifteen patients). Compared to Group I and to Group II's other symptoms, depletion (twelve cases) and weight loss (five patients) were minor.

Group III was characterized by the symptoms of over-excitation and multitudinous, crippling phobias (all fifteen). Persistent anxiety (thirteen), panics (nine), tension (all), and organ disturbances were less important. Depletion (nine), weight loss and depression (four), were minor matters. Although impaired, intellectual function was better in this group than in the other two.

The three groups had essentially the same amount of interview time with me prior to the decision to use insulin—six weeks to one and a half years.

The average insulin dose for Groups I and II was thirty units; sixty units for Group III.

Three to five electroconvulsive treatments were given to four patients in Group I, and three patients in each of the other two groups. These few treatments satisfactorily eliminated the depressive features.

RESULTS

The manner of response to insulin therapy reveals marked differences. The patients of Group I showed first signs of improvement between the seventh and tenth treatment. At the end of the course all but one, who was moderately improved, were either greatly improved or virtually symptom-free. Eleven patients gained no weight; seven patients gained three to ten pounds.

During the first three post-treatment weeks, almost one half the patients had a return of symptoms that lasted two to six weeks. These set-backs occurred as a result of some crucial issues the patients had to cope with at the time. A few weeks after the difficulties were corrected, symptoms faded. The majority of the patients were in a vigorous, symptom-free state within two months after termination of

insulin; all had achieved this level within four months.

All patients continued to have weekly interviews until most issues were met and the patients' methods of dealing with problems appeared effective. All patients have been well one to four years.

The patients in Group II required five to fifteen treatments before lessening of symptoms was noted. At the end of treatment, three patients were markedly improved; nine were moderately improved, and five had only slightly improved. Thirteen patients had gained five to seventeen pounds.

All patients continued to improve over the subsequent four months. Twelve became almost symptom-free. One patient was symptom-free for three weeks but relapsed. Three patients achieved moderate improvement. One patient died of coronary thrombosis four weeks after the termination of treatment.

All patients continued to have interviews during the subsequent several months to four years. At the present time, eleven are symptom-free most of the time, suffering brief periods of discomfort whenever they are exposed to undue stress. Two are much improved but contend with a few quiet phobias. Two are still under treatment, having relapsed considerably. One patient has resorted to hospitalization.

Apart from a marked tendency for each patient to gain weight, little can be said for Group III patients' response. One patient was very much improved at the end of treatment but this improvement lasted only five days. Six patients showed slight improvement at the end of the treatment course but this benefit was fleeting. At the present time (one to four years later) two patients are quite comfortable, but psychiatry cannot take credit for the improvement; six patients are invalided at home or in a hospital; and seven are doing very little better.

Comparing personality traits and situational stresses, Group I patients could be considered strong and effective before and after their illnesses. They needed very little in the way of attitude correction. They had been beset by an unusual number of common situational and interpersonal difficulties, closely spaced. In only two instances did a parent (father) participate in a conflict situation.

Most of the patients of Group II tended to shrink from important problem situations. They felt inadequate, inferior, in need of abundant approval; they could not defend themselves from the impositions certain relatives or community members made upon them. It is possible many had been handicapped by anxiety and its related symptoms for many years. These patients were hampered in their development from childhood through adolescence by long periods of stress within the home. It was the rule to find at least one parent enmeshed in the patients' assortment of difficulties.

The histories of the patients of Group III were tangles of symptoms, personality inadequacies, conflicts and stresses in every sphere of their lives. Most of the strains appeared to be between the patient and his parents: in eleven of the fifteen cases the parents dominated the scene and the illness. But spouses and offspring later came in to complicate the picture. It was almost impossible to appraise the patients' personalities because most of their actions were determined, or colored, by an illness that could be detected at every stage of their life histories.

CONCLUSIONS

1. Insulin subcoma therapy played an important role, even a crucial one, in restoring to health 29 of a group of 50 patients who had been suffering anxiety states of long duration, crippling in nature and apparently beyond the reach of ordinary office practice psychiatry. (Eighteen in Group I and eleven in Group II.) It was especially valuable for those patients who were much too distressed to sit through a psychotherapeutic session, or who over-reacted to a discussion of pertinent, emotionally charged material. It supplied a vital factor to other patients who had become fixed in a set of symptoms and semi-invalidism.

2. Insulin has a definite physiological, sedative effect in reducing the symptoms of tension, depletion, over-excitation, anxiety, and gastro-intestinal disturbances. This effect can-

not be achieved if treatment is given in an anxiety-generating setting, or if the patient is in a turmoil with issues between treatments.

3. Insulin seems to have no direct effect on phobias or panics. However, when the depletion factor has been counteracted and symptoms of over-excitation have been reduced, panic reactions tend to be fewer and lighter. As the patient feels better and regains confidence in his powers to go on, and as he regains his self-esteem, recently developed phobias clear in a few months. Long established phobias, however, continue in their habitual patterns.

4. The treatment apparently is most effective in those patients who had adequate pre-illness personalities, whose lives have not become hopelessly tangled with difficult people and unmanageable issues, and whose illnesses have not been so lengthy that well fixed phobias complicate every turn.

5. There is evidence that insulin brings about a reversal of certain symptoms of anxiety states; that it arrests the course and development of the illness. It thereby facilitates psychotherapy and enables the patient to deal more effectively with his problems.

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25 Trinity Place

OPERATIVE CHOLANGIOGRAPHY

Diodrast Is Injected Directly Into Common Duct; Duct Opening and Surgical Exploration Seen Often Unnecessary

A safe, quick and simple x-ray method for diagnosing gall bladder disorders by direct injection of the radiopaque substance into the common duct is recommended in a report published in the *Annals of Surgery* (134:346, 1951). Stones, strictures and other disorders, it is said, can be detected more effectively than by other technics, including the actual opening and exploration of the duct by the surgeon.

Called operative cholangiography, the procedure has been employed in 4056 cases by Mixter, Hermanson and Segel of Beth Israel Hospital and Harvard Medical School, Boston.

"Radiographic visualization", they concluded, "can lower the incidence of unnecessary common duct exploration, increase the safety of biliary tract surgery, and avoid secondary operations by demonstrating overlooked common duct stones".

The cystic duct is first surgically exposed. Then the duct is tied at its junction with the gall bladder, and a tube is inserted below the tie and passed into the common duct. The surgeons inject 3 to 5 c.c. of the opaque substance and make an x-ray exposure. An additional 5 to 10 c.c. is then injected and a second film taken.

Wet films are brought to the operating room and read by the radiologist and surgeon in an average time of 6 minutes. If the cystic duct is occluded direct injection into the common duct may be made, with a narrow gauge tonsil needle.

If a gall bladder operation is performed, a "check-up cholangiography" is carried out through the T-tube before the abdomen is closed. This procedure was employed effectively in a series of 146 cases, and the "immediate" cholangiography, before opening the duct, was performed in 260 cases. There were no duct injuries in any of the series of 406 cases, the report points out.

RESISTANT "ANIMAL-TYPE" RINGWORM INFECTION OF THE SCALP TREATED WITH X-RAY THERAPY

MAX BRAITMAN, M.D., West New York, N. J.

Tinea infection of the scalp due to microsporon lanosum—the so-called animal type—is common. It is characterized by large, boggy inflamed purulent areas. As a rule, it responds relatively well to the usual fungicide therapies. However, in the past year, three cases have come under observation which did not respond to routine medication. Clinically, the lesions were those of the *microsporon audouini* —(the human)—type of infection-dry, grey, scaly indolent patches. These patients finally had to be epilated with x-ray therapy—either totally or partly.

CASE ONE

A six year old boy had a one-inch area of partial alopecia on the right occiput. The involved hairs fluoresced under filtered ultra-violet light. Culture showed a *microsporon lanosum* infection. He was given salicylanilide[4] ointment. After two weeks, there was no change. Decupryl[1] liquid was tried. One month after starting this therapy, several new areas of infection appeared. Ammoniated mercury ointment was applied to sites previously covered with tincture of iodine. This combination resulted in slight pustulation. Podophyllin 20 per cent in alcohol was without effect. Finally, after ten weeks of fruitless local treatment, the entire head was epilated with x-ray therapy using the five point Kienböck-Adamson technic. The epilation was total and complete.

With x-ray, the affected areas reacted violently. There was marked pustulation with drainage. Healing was good with a regrowth of hair within several months.

CASE TWO

A twenty-two month old girl had a scalp infection of six months' duration—a 1½ inch dry scaly patch on the right temporo-parietal area which fluoresced with infected hairs. Ammoniated mercury ointment and Sopronol[2] ointment were among the known medications used. Two cultures were positive for *microsporon lanosum.* Various preparations were used sucessively — podophyllin 20 per cent in alcohol; Decupryl[1] liquid Tricholysin[3] ointment (caprylic acid) — all without effect. After one month more infected hairs appeared. One unit of x-ray unfiltered was given to the involved area and for one inch beyond its border. The infected area pustulated and epilation was complete. All the infected hairs were gone within three weeks. Healing was good.

CASE THREE

A two year old girl had a one inch area of alopecia on the temporal area—dry grey scaly—with fluorescent hairs and *microsporon lanosum* infection on culture. Involvement was of two months' duration. Various salves had been used. Decupryl[1] liquid and Tricholysin[3] (caprylic acid) ointment were without effect. After two months, spot x-ray therapy—one unit unfiltered—was given to the involved area plus one inch beyond. Epilation was good. No reaction was observed. Healing was complete with regrowth of hair.

While spot epilation is not advised, it was used successfully in these cases as well as in several others under my care. Observation over several weeks to be certain that there are no new sites is a prime necessity. After x-ray, the treated site is covered with adhesive and the area treated with Decupryl[1] liquid, while the rest of the scalp is treated with fungicide ointment.

Most unusual feature of these cases was the behavior simulating *audouini* type of infection—both in appearance of the lesions, the clinical course and failure to respond to varied local treatment plus pustulation after x-ray therapy and finally healing.

1. Decupryl is a tradename registered by Crooks Laboratories of New York for their brand of a copper undecylenate, undecylenic acid, dicotyl sodium, solfosuccinate tetra-chlor ethylene and isopropyl.
2. Sopronol is a proprionate caprylate tradenamed by Wyeth, Incorporated of Philadelphia.
3. Tricholysin, a trademarked product of Kelgy Laboratories, New York, is a mixture of caprylates and propyl alcohol in a water miscible base.
4. Salinidol is a salicyanilide ointment registered by the Doak Company of Cleveland, Ohio.

412 Sixtieth Street

BEDSIDE MANAGEMENT OF COMMON CARDIAC EMERGENCIES

ALBERT ABRAHAM, M.D., Morristown, N. J.

It is not always easy to obtain the more complicated laboratory procedures at the time of a cardiac emergency; but it is usually possible to arrive at a reasonable working diagnosis. In general, the diagnosis can be made from the history with little additional assistance. For example, the onset of acute coronary occlusion, or the development of a paroxysmal tachycardia, or the appearance of showers of premature systoles, may be so characteristic as to permit diagnosis on the basis of the history alone. The patient is not always able to give an accurate report so that the family must be interviewed. Careful attention to information available from the family, nurses, or others present during the episode may provide usful information, contributing considerably to the clarity of the diagnosis.

The physical examination, of course, should be thorough even though circumstances may require it to be rapid.

Although extensive laboratory data is not always available quickly, simple procedures such as a blood count, urinalysis, blood chemical determinations, and chest x-rays may contribute helpful data. At other times, the situation is not so acute as to prevent the taking of electrocardiograms or even venous pressure and circulation time determinations.

Following is a brief discussion of the more common cardiac emergencies and their management.

(1) *Hemopericardium and Tamponade:* Whether this results from trauma, from a lesion in the heart or major vessels, or from sudden accumulation of pericardial fluid, the management is the same. The patient should be placed in bed at complete rest. Primary step is the immediate correction of shock and cardiac failure. Pericardial tapping may be accomplished later if the patient's condition or the diagnosis warrants it. Surgery is not part of the emergency management. If an infection, amenable to specific therapy, is present, the required medication is administered.

(2) *Acute Cardiac Failure With Normal Sinus Rhythm:* The management of acute cardiac failure in the presence of a normal sinus rhythm resolves itself into relieving the burden imposed on the myocardium. In conditions such as paroxysmal nocturnal dyspnea, hypertensive cardiovascular disease with a high peripheral pressure, and valvular heart disease of rheumatic origin, there may occur sudden acute cardiac failure. The following regime will usually make the patient comfortable as well as produce the desired result.

(a) Absolute bed rest and the administration of a sedative.
(b) The administration of oxygen.
(c) The administration of aminophylline Grams 0.5 intravenously if bronchospasm is present as evidenced by wheezing respirations.
(d) The administration of a mercurial diuretic, one cubic centimeter (2 c.c. may be given if the patient has received it previously) intramuscularly.
(e) Liberal amounts of water may be given by mouth.
(f) In special instances if the ventricular rate is above 60 the patient may be rapidly digitalized. (for example, Lanatoside C, 1.6 milligrams intravenously in a patient who has had no previous digitalis.)

(3) *Acute Pulmonary Infarction:* Management resolves itself into three activities: (a) treatment of shock, (b) treatment of right ventricular failure, and (c) treatment of the primary disturbance. The usual methods of treating shock are applied immediately: Papaverine hydrochloride, 64 milligrams intravenously, warmth, Trendelenberg position, oxygen, and transfusion. When right ventricular failure is present, the routine listed for acute cardiac failure should be instituted. Treatment directed at the infarction should consist primarily of Depo-heparin[1] 200 to 400 milligrams intramuscularly, or of surgical intervention if the immediate diagnosis war-

1. Depo-heparin is a heparin-gelatin-dextrose combination tradenamed by the Upjohn Company.

rants it and if a trained surgical team is available.

(4) *Thyrotoxicosis:* Treatment of this condition occasionally entails the management of associated cardiac emergencies. When acute cardiac failure is present, the treatment should be as outlined for that condition. With paroxysmal auricular tachycardia, or paroxysmal auricular fibrillation (with or without the complication of acute cardiac failure) the patient should be given a single dose of Lanatoside C 1.6 milligrams intravenously.

Thyrotoxicosis in itself requires treatment, and the patient who has not received specific therapy recently would profit from the oral administration of 50 milligrams of propylthiouracil every six hours.

(5) *Auricular Tachycardia:* A simple procedure often effective in this disturbance is the application of pressure to the carotid sinus or to an eyeball. Pressure should be applied first on one side then on the other, and if necessary to both sides simultaneously. Several short and quick applications of pressure are preferable to the massage type of pressure. When carotid sinus pressure is planned, a syringe containing atropine sulfate 1/50 grain and a tourniquet should be prepared in advance. If complete heart block is produced, the atropine sulfate is given intravenously. If the pressure maneuvers fail, the patient should then receive 1.6 milligrams of Lanatoside C intravenously. If necessary, the therapy for cardiac failure (listed above) should be instituted.

(6) *Auricular Fibrillation:* In auricular fibrillation, with a very rapid ventricular rate, and with the production of severe distress to the patient, the basic therapy should be either digitalization or the administration of quinidine.

If digitalization is chosen, the patient is given 1.6 milligrams of Lanatoside C intravenously.

If quinidine is chosen the patient should receive a test dose of quinidine sulfate 0.2 Grams (3 grains) orally. If no idiosyncracy is noted in two hours, the patient should then be given 0.4 Grams (6 grains) by mouth every two hours until five doses have been administered or until the desired effect is obtained. When quinidine is given it is desirable to take an electrocardiogram prior to each successive dose, since the pattern may be returned to a sinus rhythm with a very rapid rate. Sometimes it is not possible to determine clinically whether or not the change in rhythm has occurred. The following conditions should be kept in mind, since they are all contra-indications to the use of quinidine:

1. Recent history or signs of embolism.
2. Marked, long standing mitral stenosis.
3. Long standing auricular fibrillation or cardiac failure of long duration.
4. Bacterial endocarditis.
5. Active or toxic myocarditis.

(7) *Ventricular Premature Systoles, Ventricular Tachycardia:* The treatment of these two similar conditions may be carried out with the use of one of three drugs. Ventricular premature systoles may be suppressed readily by the administration of quinidine as suggested above under "Auricular Fibrillation", by the administration of Lanatoside C (1.6 milligrams intravenously) or by the administration of Pronestyl.[2] When Pronestyl[2] is given, 200 milligrams may be injected intravenously over a period of five minutes; or the patient may be given 500 milligrams orally. Ventricular tachycardia may be treated in the same fashion as ventricular premature systoles. Here, as in auricular fibrillation, serial electrocardiograms are desirable to ascertain when a change to sinus rhythm has taken place.

(8) *Acute Coronary Insufficiency:* The patient should be placed at rest and immediately given papaverine hydrochloride (one grain) intravenously. The patient should also be given nitroglycerine (grains 1/100) sublingually. If the pain persists more than a few minutes, oxygen should also be administered. With acute cardiac failure the patient may require digitalis or diuretic therapy as outlined previously. Morphine is rarely required to alleviate the pain.

(9) *Acute Myocardial Infarction:* This serious and at times frightening condition should be handled in the following manner.

2. Pronestyl is a tradename of E. R. Squibb and Sons for their brand of amino-ethyl-benzamide-hydrochloride.

1. The patient should be placed completely at rest.
2. Pain and apprehension should be alleviated immediately.
3. Papaverine hydrochloride should be given intravenously. Dose is one grain.

If this routine does not produce a satisfactory result within 30 minutes, then a quarter of a grain of morphine sulfate should be given intravenously over a period of five minutes. The morphine may be repeated once if a satisfactory result is not achieved within 30 minutes. Further doses of morphine should not be given at intervals of less than four hours because excessive administration of morphine may cause depression of respiration. Oxygen should be given as soon as possible. In acute cardiac failure the patient should receive a mercurial diuretic intramuscularly. If the other common indications for digitalization are present, the patient should receive Lanatoside C 1.6 milligrams intravenously. Should shock develop this must be treated strenuously with:

1. Transfusions of blood and plasma slowly.
2. Infusions of moderate amounts of normal saline solution (1000 to 2000 cubic centimeters) subcutaneously *slowly* with a hyaluronidase preparation.
3. Neo-Synephrine[3] 100 milligrams subcutaneously or adrenal cortical extract 2 cubic centimeters intramuscularly.

(10) *Stokes-Adams Symdrome:* This syndrome manifested primarily by bradycardia, heart block, and syncope responds readily to treatment with epinephrine. The dose is one cubic centimeter of the 1 to 1000 solution subcutaneously. At the same time the patient should be given 25 milligrams of ephedrine sulfate by mouth.

139 South Street

WILL YOU SERVE ON A STATE SOCIETY COMMITTEE?

Any member interested in serving on a committee of The Medical Society of New Jersey for the fiscal year beginning in May 1952, should submit his name to the Executive Offices in Trenton. The member should also indicate on what committee he feels he would be most useful. Dr. Harrold A. Murray, the president-elect, desires to have small but very active committees during his administration and will make every effort to appoint members interested in this service.

PANEL DISCUSSION ON MENOPAUSE

A panel discussion on the menopause will be held at the Main Lecture Hall of New York University's College of Medicine on Tuesday evening, February 19. Members of the panel will be: Drs. Theodore Neustadter, Ephraim Shorr, Robert Hotchkiss and Raphael Kurzrok. The meeting starts at 8:30 p. m. For tickets (gratis) write to New York University at 100 Washington Square, New York 3, New York, attention of Medical Alumni Office.

3. Neo-Synephrine is a brand of methyl amino hydroxy ethylbenzene hydrochloride tradenamed by Winthrop-Stearns, Inc.

PANEL DISCUSSION ON DIARRHEA

New York University announces a panel discussion on diarrhea for Tuesday evening, January 29, beginning at 8.30 p. m. Members of the panel will be Dr. L. Emmet Holt, Dr. Horace Hodes, Dr. Henry Barnett and Dr. Edward L. Pratt. The meeting will be held at 477 First Avenue. Admission is by ticket only. Tickets may be obtained, without charge, by writing to the Medical Alumni Office, New York University, 100 Washington Square, New York 3, N. Y.

CRITERIA FOR REPLACEMENT TRANSFUSION †

Roy Pollack, M.D.,* Englewood, N. J.

The responsibility for prompt and effective treatment of erythroblastosis fetalis is shared by the obstetrician and the pediatrician. The obstetrician must anticipate erythroblastosis on the basis of the history and the serologic evidence of maternal iso-immunization. The pediatrician must study clinically and hematologically each suspected case of erythroblastosis to determine whether the effects of iso-immunization on the baby are such as to require replacement transfusion.

Erythroblastosis of such degree as to require replacement transfusion rather than just careful observation and perhaps simple transfusion is the result of the union of an Rh negative mother and an Rh positive father. Rh incompatibility is responsible for about 92 per cent of the cases of erythroblastosis. The disease may occasionally result from main blood group incompatibilities and also other less well known blood factor incompatibilities. However, the Rh factor is by far the most antigenic of the blood factors responsible for erythroblastosis, and for practical purposes, all cases of erythroblastosis requiring replacement transfusion are due to Rh incompatibility.

Given an Rh negative mother and an Rh positive father, certain data must be obtained from the history. Parity is important because erythroblastosis is nine times more common in multiparous women than in primiparous women. Previous pregnancy is the most common means of iso-immunization. Transfusion with Rh positive blood is another source of potent antigen. An accurate history of transfusion is difficult to obtain; for example, not so many years ago intramuscular injection of blood was a common pediatric procedure for the treatment of hemorrhagic disease of the newborn, and it is easy to see how there can be no record of such a procedure. Thus primiparity and the absence of history of transfusion with Rh positive blood is no guarantee that an Rh negative mother and an Rh positive father may not produce an erythroblastotic infant.

Information concerning the results of previous pregnancies is important in evaluating the chances of an Rh negative mother and an Rh positive father to produce a normal or diseased infant. History of late fetal deaths is compatible with erythroblastosis. Erythroblastosis in older siblings is strongly suggestive that there will be trouble with the pregnancy under consideration, especially if the father is homozygous for the Rh factor thus eliminating any possibility of an Rh negative infant.

Given two Rh negative women with the same opportunity for contact with Rh antigen, we do not know why one may develop a high degree of iso-immunization and the other may develop no iso-immunization. To help determine whether such iso-immunization exists, blood specimens for antibody studies should be taken early in pregnancy. If the early tests are negative, they should be repeated at 36 weeks. If the early tests are positive, they should be repeated at 26, 32 and 36 weeks to determine whether the amount of antibody is increasing.

Though the history and serologic evidence of maternal iso-immunization may suggest strongly the probability of an erythroblastic infant, replacement transfusion should *not* be performed unless the infant actually presents signs of erythroblastosis. During delivery it is helpful to note whether the amniotic fluid and vernix caseosa are stained golden-yellow. A large pale placenta is also indicative of erythroblastosis.

Repeated physical examination of an infant suspected of erythroblastosis is as important as repeated hematologic examination. Jaundice is usually not present at birth, but it may become evident a few hours later. Such

† Read at Alumni Day Program, Englewood Hospital, June 21, 1951.

* Attending Pediatrician, Englewood Hospital.

rapidly developing jaundice in an infant suspected of erythroblastosis almost invariably demands replacement transfusion as does rapidly appearing pallor. A large spleen and liver at birth, lethargy and hemorrhagic tendency can be produced by so many conditions in addition to erythroblastosis that these findings do not rank in importance with hourly increasing jaundice and pallor as criteria for replacement transfusion.

When erythroblastosis is anticipated, a specimen of cord blood should be taken for the following procedures: Rh factor and blood grouping, Coombs test, hemoglobin determination, red cell count, and smear for number of nucleated erythrocytes and red cell morphology. Of these various procedures, the Coombs test which is theoretically very important has not as yet proved of value to us. The discovery of an Rh negative infant is reassuring, especially when the mother showed no antibodies. When the mother shows a high antibody titer, we must consider the possibility of a false Rh negative test due to the large quantity of antibodies on the red cell which may interfere with Rh typing. Hemoglobin below 14.5 Grams and a red cell count below 4,500,000 are suspicious of more than mild erythroblastosis and require repetition in several hours. A significant fall in red cell count and hemoglobin in several hours is indicative of erythroblastosis of such severity as to require replacement transfusion. Nucleated red cells in excess of 15 per 100 leucocytes are abnormal and almost invariably accompany the severer cases of erythroblastosis. However, we do not perform replacement transfusion on the basis of increased number of nucleated red cell count alone.

Such are the criteria on which the decision to perform replacement transfusion is based. Since replacement transfusion is most effective when performed early (preferably during the first several hours of life) best results will be achieved when all physicians doing obstetrics let the "replacement team" know when the birth of an erythroblastotic infant is anticipated. By so doing, no time will be lost in evaluating each case from the standpoint of the need for replacement transfusion.

275 Engle Street

ONE HUNDRED YEARS AGO

From the report of the standing committee for the year 1849: "To arrest the nausea of erysipelas, no remedies have proved so effectual as ammonium carbonate, and a prescription composed of aqua camph, one fluid ounce, aromatic spirits of ammonia, 1½ fluid ounces, given in teaspoonful doses *pro re nata*. To the great value of quinine in erysipelas, your committee can give their united testimony. The local treatment is a matter of much interest, and there is no question on which there is more contrariety of opinion. Some physicians advocate the nonapplication of external means; others are bold to approbate the virtues of a variety of substances. Some claim great relief from cold applications. Others favor hot and emmollient fomentations. Hog's lard and molasses have their advocates; pressed into service with equal claims of restorative powers are buckwheat or rye meal, creosote, and nitrate of silver." (Page 453 of 1849 *Transactions of The Medical Society of New Jersey.*)

DR. H. I. GOLDSTEIN HONORED

Dr. Hyman I. Goldstein has been named lifetime historian for the New Jersey Gastroenterological Society and also lifetime historian of the National Gastro-enterological Association. Dr. Goldstein is a member of our Camden County Medical Society.

A NEW NITROGEN FREE, HYPO-ALLERGIC ANTIPRURITIC

O. J. Sokoloff, M.D., and F. M. Berger, M.D., New Brunswick, N. J.

The large number of antipruritic remedies available on the market indicates that none of them is completely satisfactory. This is not surprising in view of our ignorance of the etiology of the itch. The preparations used for the relief of pruritus can, according to composition, be divided into three classes: (1) Bland emolient salves, (2) preparations containing local anesthetics, and (3) salves containing antihistaminic substances.

Bland preparations are used with the hope of "covering" the nerve endings with a protective coating. Local anesthetics are used to numb the nerve endings. Antihistamines are used on the assumption that itching is caused by a release of histamine in the skin. However, local application of an antihistamine does not decrease the size of histamine wheals.[1] The opinion has been expressed[2] that antihistamines used in the topical treatment of pruritus are effective not because of their antihistaminic property but because of their local anesthetic action.

Both the antihistaminic and local anesthetic agents generally used for the relief of pruritus have the common disadvantage of causing sensitization. Lane and Luikart[3] have drawn attention to the widespread occurrence of sensitization from the commonly used local anesthetics. The incidence of sensitization[4] after topical treatment with antihistamines was 3 to 7 per cent.

Most antipruritic agents causing sensitization possess a nitrogen containing grouping. Landsteiner[5] has shown that compounds possessing such a grouping (while not antigenic by themselves) can combine with body proteins to become full antigens. It appeared worthwhile to attempt the preparation of a substance which would possess local anesthetic activity and at the same time would not contain nitrogen and also be free of other reactive chemical groups likely to conjugate with body proteins.

It has been previously shown[7] that mephenesin (3-*o*-toloxy-1,2-propanediol) widely used as a skeletal muscle relaxant, possesses local anesthetic properties. A number of allied nitrogen-free compounds were prepared and investigated for their local anesthetic activity on the rabbit's cornea. It was found[6] that carbalkoxy derivatives of 3-phenoxy-1,2-propanediol possessed the greatest local anesthetic action. Of these, 3-(*p*-carbo-*n*-butoxyphenoxy)-1,2-propanediol appeared to be of greatest interest and was studied in greater detail. This substance was named Tioxine.*

Chemically pure Tioxine* is a waxy white crystalline solid with a melting point of 59 to 60. It is insoluble in water but dissolves easily in oils, fats and organic solvents. Tioxine* tested on the rabbit's cornea caused loss of the wink reflex in all the rabbits tested when applied in a concentration of 0.15 per cent. An 0.075 per cent solution caused loss of the wink reflex in five out of ten animals. To obtain comparable results a 0.5 per cent solution of procaine was required. Thus Tioxine* possessed stronger local anesthetic properties than procaine when tested in this manner. Tioxine* and procaine were of approximately equal potency when tested on intracutaneous injection to guinea pigs.

Tioxine* did not produce irritation or sensitization when applied repeatedly to the skin of guinea pigs and rabbits and to the cornea and vagina of rabbits. On oral administration of suspensions of Tioxine,* mice tolerated doses as high as 4 Grams per kilogram. On intraperitoneal injection to mice, the mean lethal dose was 800 milligrams per kilogram. Thus, Tioxine* is very markedly less toxic than commonly used local anesthetics and antihistaminics.

For clinical purposes, the active ingredient was incorporated in a Carbowax† base. The resulting salve was colorless, non-staining and freely soluble in water. It had a faint aromatic odor. The preparation was used on patients of all ages, both sexes and the usual

1. Perry, D. J.: J. Investigative Dermatology, 2:95 (1947).
2. Reiss, F., and Kern, A. B.: Journal of Allergy, 21:160, (1950).
3. Lane, C. G., and Luikart, R.: Journal of the American Medical Association, 146:717 (1951).
4. Waldriff, G. A., Davis, J., and Lewis, G. M.: Archives of Dermatology and Syphilology, 61:361 (1950), and Davis, J.: Bulletin N. Y. Academy of Medicine, 26:686 (1950); and Strauss, M. J.: Journal of Investigative Dermatology, 11:155 (1948).
5. Landsteiner, K.: *The Specificity of Serological Reactions.* Charles C. Thomas, 1936.
6. Berger, F. M.: Journal of Pharmacology, 93:470 (1948).
7. Berger, F. M., and Bradley, W.: British Journal of Pharmacology, 1:265 (1946).

* Tioxine cream was supplied by Wallace Laboratories, Incorporated, New Brunswick, New Jersey.

† Carbowax base is a mixture of carbowax and polyethelene glycol prepared by the Carbide and Carbon Chemical Company.

variety of occupations seen in private practice. The only feature of selection was the physical state of eruption. Application of the salve was restricted to cases suffering from subacute and dry eruptions.

To determine effectiveness and toxicity of Tioxine* cream several clinical procedures were carried out. Patch tests using Tioxine* were carried out in 150 subjects. These tests were controlled by a series in which 5 per cent Benzocaine[8] ointment was used. Each patient was patch tested twice and there was at least a week's interval between the first and second test. Repeated testing was carried out to facilitate elicitation of both primary irritation and sensitization. Tioxine* cream did *not* cause primary irritation or sensitization in any of the subjects. Benzocaine[8] ointment (while not a primary irritant) caused sensitization in four subjects.

To obtain an estimate of efficacy, a series of patients with various symmetrically distributed pruritic dermatoses used both Tioxine* cream and 5 per cent Benzocaine[8] ointment, applying the preparations to corresponding areas. Thus, if the Tioxine* cream was used on the right arm, the Benzocaine[8] ointment was used on the left. Similarly, to rule out any effect due to the ointment base itself, we applied Tioxine* cream and a similar preparation without active ingredient to symmetrical body areas of patients without informing them about the identity of the preparations.

The table shows the effects obtained with Tioxine* cream, the cream base without the active ingredient and Benzocaine[8] ointment in 200 patients suffering from various dermatologic conditions. The cream base without the active ingredient possessed a mild and often indefinite antipruritic action. Tioxine* cream had in almost every case a stronger antipruritic action. Thus, patients were able, in most cases, to pick correctly the preparation containing the active ingredient.

The antipruritic activity of Benzocaine[8] ointment was of a similar order as that of Tioxine* cream. In certain conditions, such as pruritus ani and vulvae and atopic eczema, Tioxine* cream appeared somewhat more effective than Benzocaine.[8]

EFFECT OF TIOXINE* ON ITCHING

Cases	Diagnosis	No Change	Itching Stopped	Itching Lessened	Itching Aggravated
50	Contact Dermatitis	0	0	49	1
25	Seborrheic Eczema	0	25	0	0
25	Urticaria	0	0	25	0
20	Neurodermatitis	0	20	0	0
20	Lichen Simplex	0	20	0	0
20	Atopic Eczema	0	19	0	1
15	Tinea Pedis	0	0	15	0
11	Pruritus Ani	0	11	0	0
10	Tinea Cruris	0	0	10	0
9	Pruritus Vulvae	0	9	0	0
7	Psoriasis	7	0	0	0
5	Lichen Planus	0	5	0	0
5	Varicose Eczema	0	5	0	0
3	Infantile Eczema	0	0	2	1
225		7	114	101	3

Two hundred patients were treated with Tioxine* cream. One case each of atopic eczema, infantile eczema and contact dermatitis were aggravated by producing sensitization. This incidence of sensitization (1.5 per cent) in patients suffering from allergic states is in contrast with the absence of sensitization observed with 200 normal subjects. Benzocaine[8] ointment caused sensitization and aggravation of symptoms in 8 out of 110 cases, an incidence of over 7 per cent. Thus, Benzocaine[8] ointment had markedly stronger sensitizing properties than Tioxine* cream.

Tioxine* cream had no direct curative value in the dermatoses in which it was tried. Appropriate therapeutic agents were therefore used concurrently with Tioxine* in all conditions that were not self-limiting. Any therapeutic efficacy which it possessed was the result of its antipruritic action. This property served to lessen the complications of excoriation and secondary infection. It has been previously shown[9] by one of us (O.J.S.) that the prevention of these complications by occlusion dressing speeds up recovery in most cases.

Certain patients felt a transient burning sensation when Tioxine* cream was first applied. This sensation was similar to that occasionally observed[10] after application of diphenhydramine ointment. The discomfort

8. Benzocaine is ethyl para amino-benzoate manufactured and distributed by Merck and Company.
9. Sokoloff, O. J.:Journal of The Medical Society of New Jersey, 43:373 (1946).
10. McGavack, T. H., Schulman, P., and Elias, H.: Archives of Dermatology and Syphilology, 57:308 (1948).

was short-lived and did not give rise to irritation.

In all patients where the preparation was effective there was no loss of effectiveness over a period of months. Tioxine* cream was used for two weeks as a minimum test period. This was considered sufficient time to determine antipruritic efficacy. Only in cases of aggravation was therapy discontinued immediately.

SUMMARY

1. Tioxine* is a local anesthetic of a new structure. It is nitrogen-free, chemically inert and thus less likely to cause sensitization. The toxicity of Tioxine* is very low.

2. Two hundred patients with various selected dermatoses were treated with Tioxine* cream for the symptomatic relief of pruritus. Clinical response was excellent except for three instances of aggravation.

3. Tioxine* cream was at least as effective as a 5 per cent Benzocaine[8] ointment and had a markedly lower sensitizing index.

69 Paterson Street

PHYSICIANS OFTEN FORGET THAT THE blood-pressure cuff can be a great help in doing intravenous injections. It is a simple method of arriving at the correct degree of obstruction to venous flow. This method has the advantage that after the needle has been introduced, the pressure can be reduced gradually and without jerking by turning the screw valve. This avoids the danger of the needle slipping out of the vein as sometimes happens with a tourniquet of the ordinary type.

♣ ♣ ♣

WHILE THE CHART AND CALCULUS BOYS are busy figuring the cost of medical care, they might include the savings effected by modern medicine. It's easy enough to figure the dollars and cents spent for medical fees, nurses, drugs, and hospitals. And because it comes to a large sum, the "economists" are clamoring for some sort of drastic action. But how about the dollars and cents savings in man-power kept and made healthy enough to work? How about the savings effected by not fighting epidemics which medical science has annihilated? Maybe if these could be calculated and offset against the cost of medical care, the health bill wouldn't be in the red. And some politicians might be out of jobs.

♣ ♣ ♣

TUBERCULOSIS IS A VANISHING DISEASE. Perhaps we are a little hypnotized by that fact. When this century began we know that tuberculosis claimed more than 200 victims annually from every 100,000 of our population; today, tuberculosis has been driven from top billing down to a shaky seventh. But tuberculosis is still the leading cause of death in those of college age. Tuberculosis is still as much of personal catastrophe for the individual who contracts it today as it ever was in the past. Tuberculosis has lost none of its ability to ruin a career, wreck family budgets, burden taxpayers, or bring suffering and disability to thousands of Americans, no one of whom deserves or needs to contract tuberculosis if every one utilized fully what medical science knows and has to offer. —Charles E. Lyght, M.D.

♣ ♣ ♣

THE TREND TOWARD SURGICAL TREATment of tuberculosis is perhaps the most significant and far-reaching change which has come about in the tuberculosis hospital field. This has involved changes in design and equipment of the hospital, in the organization by the staff, in provision for nursing of surgical cases, and development of closer relations with general hospitals. Wherever the tuberculosis hospital is not prepared to meet the demand for better operating rooms, laboratories, and roentgen ray equipment, the facilities of the general hospital must be utilized. — Penna. Med. Jour.

♣ ♣ ♣

PEOPLE STUDY MEDICINE FOR ECONOMIC motives. But if only economic motives were known to physicians, the discussions at medical meetings would not have advanced the art to its present state. Can you imagine a surgeon saying to his colleagues: "Boys, I've got a new operation, and is it a whiz! It cuts down overhead by 15 per cent and enables me to jack up the fee by 25 per cent." No, they discuss their new achievement in terms of benefit to the patient.—Temple Burling in "Mental Hygiene in Business."

♣ ♣ ♣

THE PATIENT HAS NO IDEA THAT CASES similar to his may be quite common. He believes that his case is unique and he may have been waiting days to pour out his troubles to the doctor. The physician cannot under these circumstances, after hearing the bare highlights of the case, unceremoniously call a halt to the patient's recitation. By so doing he runs the risk of missing details of the case which really are important, as well as appearing disinterested or of discrediting the patient's ability to evaluate his own illness.—"Disease and the Man"—Lapham.

THROMBO-ANGIITIS OBLITERANS IN WOMEN

REVIEW AND REPORT OF A PROVED CASE

NATHAN FRANK, M.D.,* Jersey City, N. J.

Thrombo-angiitis obliterans (Buerger's Disease) in the female is as rare as the proverbial hen's tooth. While the incidence is probably increasing, there have been, to date, only 45 cases of this disease in women reported in all the world's literature. In only a small fraction of these, has the diagnosis been verified by histologic study.

The largest group has been reported by Silbert.[1] He found it in 25 women in an entire series of 1600 cases of thrombo-angiitis obliterans. In the first thousand patients with this disease, there were only two women; but in the last 600 there were twenty-three women. Although the incidence for the entire group was slightly over 1 per cent, in the ten years prior to his report it had risen to 4 per cent. In 1932 Horton and Brown[2] were able to find only 7 cases in the literature and added 10 of their own. A review of these indicates that only 3 (one reported by Meleney and Miller[3] and two by Horton and Brown) were proved by histologic study. Six of the other cases must be considered as fairly typical examples but without histologic proof. These include two reported by Buerger[4] and four by Horton and Brown.[2] Whether the remaining eight were cases of thrombo-angiitis obliterans is distinctly questionable, both from the clinical and pathologic standpoints according to the details given in the reports. Between 1935 and 1946 only three cases were observed at the Mayo Clinic—an institution where there is present a very acute clinical awareness of peripheral vascular diseases. Tedford and Stapford[5] cited two cases in the British Isles. LeFevre and Burns[6] also reported two cases from the Cleveland Clinic. Wright and Van Dellen[7] in 1937 reported only a single case in a woman, although they were engaged in a very large clinic, and in private practice specialized in peripheral vascular diseases. The author has discovered only one woman with Buerger's Disease in a fifteen year period at the Jersey City Medical Center. This case is reported below. Two other women with clinical findings compatible with the diagnosis were seen in private practice during the same period. However, histologic verification was not obtained.

Many features of the disease are common to both the male and female. There are, however, some points of difference in the clinical picture in the two sexes. Thrombo-angiitis obliterans in both sexes is a disease prevalent exclusively in smokers. Personally, I have never seen Buerger's Disease in a non-user of tobacco. Hines, Allen and Barker[8] say that they *have* seen it in a non-smoker. It is a disease of young people, usually manifesting symptoms between the ages of 20 and 45. Hypertension, diabetes and syphilis are seldom present; and when they are, they play no role. Segmental thrombophlebitis is noted in approximately 40 per cent of the patients. This clinical sign may antedate the arterial lesion. Vascular calcification is not demonstrable on roentgen study. One aspect of the disease that seems to be more frequent in the female is the initial involvement of the hands. In the male, the fingers may also become affected but the disease almost exclusively has its onset in the lower extremities. It is usually much later in the progress of the disease that the upper extremities become involved. The disease seems to advance more rapidly in women. Silbert[1] had noted a higher incidence of cerebral vascular disease in his female patients.

CASE REPORT

An American housewife of Italian parentage, 34 years of age, was first seen December 30, 1949, complaining of a painful ulcer at the tip of the left great toe. The lesion had been present for three weeks. It had appeared without any known precipitating factor. Both feet felt cold, the left more so. Pain in the toe and foot were severe and much worse at night. Sleeping in bed was difficult. Some relief was obtained by holding the foot in the dependent position. When the pain was severe, she slept in a chair. The pain was described as of a "burning" quality. For the preceding three years she had noticed decreasing walking tolerance. Now

* Dr. Frank is chief of the Peripheral Vascular Clinic at the Jersey City (N. J.) Medical Center. This work is from the Department of Medicine of that hospital.

1. Silbert, Samuel: American Heart Journal, 36:757 (1948).
2. Horton, T. T., and Brown, G. E.: Archives of Internal Medicine, 50:884 (1932).
3. Meleney, F. L., and Miller, G. G.: Annals of Surgery, 81:976 (1925).
4. Buerger, Leo: *The Circulatory Disturbances of the Extremities.* W. B. Saunders Company, Philadelphia (1924).
5. Tedford, E. D., and Stapford, J. S. B.: "Two Cases of Thromho-angiitis Ohliterans in Women". Personal Communication to the author.
6. LeFevre, F. A., and Burns, J.: Cleveland Clinic Quarterly, 11:49 (1944).
7. Van Dellen, T. R., and Wright, I. S.: American Heart Journal, 13:373 (1937).
8. Allen, E. V., Barker, N. W., and Hines, E. A., Jr.: *Peripheral Vascular Diseases.* W. B. Saunders Company, Philadelphia (1946).

she would walk only about two blocks before she would develop intermittent claudication.

Symptoms of disturbed circulation had appeared about nine years before. At that time she noted "cramp-like" pains in the arms and legs. These would occur usually at night and would waken the patient. These symptoms were diagnosed as "rheumatism" and treated with various medications for three years. In 1944, her left first toe became red, cold and ulcerated. Curettage was performed and recovery occurred after several weeks. One year later, the third finger of the right hand became cold, painful and cyanotic. The digit progressed to gangrene and had to be amputated. Histologic sections revealed thrombo-angiitis obliterans (Figure 1). Subsequently she noted that exposure to cold or emotional upsets would effect the color changes in her fingers such as is seen in Raynaud's syndrome. In 1947, gangrene of the index finger of the left hand occurred and amputation was necessary.

She had smoked for fifteen years and consumed an average of twenty cigarettes a day.



Physical examination was not remarkable except for the extremities. Blood pressure was 134/70 (both arms). There was marked rubor of hands on dependency and extreme pallor on elevation. Neither radial nor ulnar artery pulsations could be felt (Allen Test). Oscillometric readings were *one* over each forearm. Nails were atrophic and ridged. The tips of the other fingers showed healed scars. An angry, irregular ulcer covered by a greenish-yellow adherent slough was present over the end of the left great toe. The ulcer and toe were exquisitely tender. Both feet manifested marked rubor on dependency and pallor on elevation. Venous filling time was greatly delayed. Neither dorsalis pedis nor posterior tibial pulsations could be felt. Oscillometric readings:

	Right	Left
Over foot	0	0
At ankle	⅜	1
Below knee	1½	1

Thermocouple studies showed marked lowering of digital temperatures of both hands and feet. X-ray of the chest was negative. Soft tissue roentgenograms failed to show calcification of vessels. Blood count, urine and serology were normal. Electrocardiogram showed a normal tracing. Blood sugar was 114 milligrams per cent. Nonprotein nitrogen was 24.

The patient was admitted to the Jersey City Medical Center on January 3, 1950. She was placed on the usual regimen of abstinence from smoking, bed rest with elevation of head of bed, sedation, local analgesic dressings, et cetera. Because of severity of the pain she was given epidural blocks on January 13, 1950, and January 16, 1950, with some relief of pain. She also received intravenous typhoid vaccine every second or third day until her discharge on February 11, 1950. At the time of her departure from the hospital the ulcer was almost completely healed and the patient entirely free of pain. She was observed until April 21, 1950, at which time, the lesion on her toe had completely closed. At this time she still had a walking tolerance of two blocks. A subsequent communication stated that she could walk eight to ten blocks without difficulty.

For years physicians interested in peripheral vascular diseases have wondered what effect the universal habit of smoking among women during the past quarter century would have on the incidence of thrombo-angiitis obliterans in the female. This question still cannot be answered definitely. The number of cases reported to date are too few statistically. The only large number of cases seen by any individual or group are those of Silbert[1] who noted an increase of 3 per cent.

In view of the possible increase in the incidence of female patients with Buerger's Disease it behooves us to be able to differentiate this condition from Raynaud's disease and syndrome. These are much more common in the female than in the male. Since the treatment in these conditions is entirely different, accurate diagnosis is essential. The following signs and symptoms should help make the differential diagnosis:

(1) Raynaud's disease is always precipitated by exposure to cold or emotional stimuli. In between episodes of digital syncope the patient has no vascular symptoms or signs. Buerger's disease is aggravated by cold but signs and symptoms are present between "attacks".

(2) Pain is severe in thrombo-angiitis obliterans whereas in Raynaud's the patient complains mostly of paresthesia (numbness, tingling) and of color changes.

(3) In Raynaud's disease, all the major arteries pulsate normally. Oscillometric readings are normal. In Buerger's disease, there is absence or diminution of pulses and oscillometric readings.

(4) Massive gangrene can and does take place in thrombo-angiitis obliterans but never in Raynaund's.

(5) Intermittent claudication never occurs in Raynaud's disease.

(6) Color changes with elevation and dependency of the foot do not occur with Raynaud's disease.

From the standpoint of treatment, the prognosis in our experience is better in Buerger's disease than in Raynaud's. A patient with a mild thrombo-angiitis obliterans can expect a complete remission if he stops smoking. In more advanced cases, the addition of sympathectomy, intravenous typhoid vaccine, vasodilators, oscillating bed, intermittent venous occlusion apparatus, good foot hygiene, reflex vasodilation by the distal application of heat, et cetera, have effected cures in most patients. Treatment of Raynaud's disease has been very unsatisfactory in many cases, particularly in those with deep-seated emotional disturbances.

SUMMARY

1. The world literature of thrombo-angiitis obliterans in women is reviewed.

2. A proved case in a 34 year old woman is presented.

3. The possibly increased incidence of Buerger's disease in women is discussed.

4. The differential diagnosis between Buerger's and Raynaud's disease is outlined.

The author wishes to express his appreciation to Mr. Felix Traugott for the photograph.

180 Bowers Street

INDISCRIMINATE REFERENCE OF ANY PATIENT whom the doctor cannot afford or does not care to treat, to a free clinic, regardless of whether or not the patient may afford a moderate or small fee, is a pernicious habit, and one which is proving to be a boomerang to the medical profession—"Disease and the Man"—Lapham.

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DR. E. V. McCOLLUM, PROFESSOR OF BIOchemistry at Johns Hopkins University, believes that animal proteins are essential to our welfare and cannot be replaced by those derived from vegetable sources. In a speech before the eighth American Scientific Congress, he pointed out that meat proteins are much more digestible than vegetable proteins. He feels that the lack of these proteins may be responsible for the inferior development of populations in tropical countries and in some industrial areas.

♠ ♠ ♠

DETECTIVE STORY WRITERS LIKE TO thrill readers with gruesome stories of the growth of hair and nails after death. Beards appear on the face of the freshly-shaven corpse, and bodies exhumed from the grave are alleged to have grown sharper, longer nails. All that happens is that the shrinkage of skin permits small stubbles of hair to appear, and allows the nails to protrude a little more than at the time of death. No scientific evidence supports the canard that any part of the body can grow or function after general body death.

♠ ♠ ♠

"It is better to wear out than to rust out."—Richard Cumberland.

"THE CONTROL OF TUBERCULOSIS BEGINS in the office of the general practitioner." So Morse points out in a recent article in the Wisconsin Medical Journal. He adds: "The family physician occupies the key position in finding tuberculosis. He plays the number-one rôle in the fight to reduce the incidence of the disease."

♠ ♠ ♠

THERE ARE CERTAIN RULES FOR A DOCtor's vacation which are, if not paramount, indeed advisable: first, avoid telephones as you would a Grand Jury; second, never register as "Doctor"; third, don't take your medical cases along with you (if you distrust your colleagues, hide in one of your traveling bags a very small first-aid outfit); fourth, do not visit hospitals, medical schools, other doctors; fifth, don't put yourself on a time schedule; sixth, even if you don't obey any of these commandments, at least take a vacation.—Journ. Mich. Med. Soc.

♠ ♠ ♠

LAVOISIER'S EXPERIMENTS, PERFORMED in the latter part of the eighteenth century, are the basis of the science of metabolism of today. He showed that animal heat was the result of the oxidation of carbon in the body and similar to the burning of any other combustible substance. In either case there occurred the consumption of oxygen and the formation of carbon dioxide.

♠ ♠ ♠

"BETTER DIETARY HABITS ESPECIALLY during the past twenty years, have enhanced inborn resistance to all diseases including tuberculosis."—Fred H. Heise, M.D.

RATIONAL USE OF CORTISONE IN RHEUMATIC DISEASES

Irving L. Sperling, M.D., Newark, N. J.

The dramatic effects of cortisone in rheumatic diseases, particularly rheumatoid arthritis, have minimized its application in other rheumatic conditions where less dramatic results are produced. By now the effects of cortisone on the course of rheumatoid arthritis[1] are a well documented story, and the toxic effects are just as adequately known and described.[2] With this knowledge has come awareness of the limitations of the drug in the treatment of these diseases, and in turn a somewhat pessimistic attitude towards cortisone's usefulness. This attitude is, in part, justified, because, to date, the methods of administration of the drug have produced little permanent effect on the course of rheumatoid arthritis. The usual results are prompt and maintained clinical remission during the period of drug administration. With cessation of therapy, there is usually swift recurrence of symptoms, often to a greater degree, as well as the post-cortisone withdrawal state. These results have deterred many physicians from attempting other methods of using the drug. There is a high probability that in this varied approach, the true therapeutic value of the drug may be found.

Permanent effects on the course of rheumatoid arthritis are not produced by the ordinary methods of administration of cortisone. However, it is the purpose of this report to suggest less conventional methods of administration which may produce more prolonged or permanent benefits. This will be illustrated by several case reports which exhibit these anticipated benefits.

CONVENTIONAL METHOD

The usual plan starts with a high dosage of cortisone, reaches a plateau in several days, and then after an indefinite period, the drug is stopped. This produces rapid clinical improvement proportionate to the stage of the disease. The improvement is maintained during the course of therapy. With cessation of the drug, there is a rapid return of symptoms within a period of days or several weeks. This occurs in at least 95 per cent or more of the cases, and is frequently associated with a group of distressing symptoms, the so-called "cortisone withdrawal" state.

This method is satisfactory only *during* the period of therapy. There are no permanent or lasting effects and for this reason, the efficacy of this method is doubtful. Furthermore the procedure produces severe psychologic disturbances in that there is a swift change of status from improvement to marked symptomatology. This psychologic upheaval produces an attitude in the patient which prevents the rapport necessary before attempting other forms of therapy.

INTERMITTENT SHORT COURSES

This method consists of short courses of the drug as outlined in the conventional method. The individual courses are resumed after the return of symptoms following the preceding course. This method produces no permanent or lasting relief. It leads to severe swings of depression and elation as the symptomatology recurs and clears.

This method has the same drawbacks as the conventional method with the added increased psychologic disturbance. It holds little promise for future use.

PROLONGED ADMINISTRATION

Cortisone has now been used therapeutically for a period of just a little over two years. Its niche in the therapeutic armamentarium has not yet been fully carved. At first, there was hope that the drug could be used indefinitely on a replacement basis, as is true with other hormonal products like insulin and thyroid. Enough time has not elapsed to determine whether permanent ill effects would result from prolonged drug use. Furthermore the time is still too short to determine its efficacy

1. Sprague, R. G., *et al.*: Archives of Internal Medicine, 85:2 (1950).
2. Hench, P. S., Kendall, E. C., Slocumb, C. H., Polley, H. F.: Archives of Internal Medicine, 85:4 (1950).
3. Freyberg, R. H.: Bulletin on Rheumatic Diseases, 1:1 (1950).

in producing permanent lasting effects. Several studies have been reported[3] in which the drug has been administered in cases of rheumatoid arthritis[4] for varying periods up to two years. These have been fairly satisfactory from the clinical standpoint with sustained remissions proportionate to the stage of the disease. In some cases the drug was discontinued during the course due to side effects, but in general these were not of a serious nature. In each case the symptoms have recurred on cessation of therapy, but no serious aftereffects have been recorded.

The case below illustrates the problems and effects of this method of administration.

CASE REPORT

A 74 year old widow developed a severe arthritis in April 1950 with involvement of hands, knees, shoulders, wrists and other joints. The symptoms were severe and her course was afebrile with a marked anemia and toxicity. A diagnosis of rheumatoid arthritis was made and ACTH was started. Because of lack of response after two weeks, intramuscular cortisone was given with spectacular relief in a few days. During a two-month period she was maintained on a dosage of 75 milligrams daily. All laboratory procedures including chemistries and electrocardiograms were normal. With a reduction of daily dosage to 50 milligrams, there was prompt recurrence of all symptoms. This was controlled by increasing the daily dosage to 100 milligrams for a week. Then there was a gradual reduction to a maintenance daily dosage of 67.5 milligrams. In August 1950, she gained weight rapidly and developed peripheral edema. With rigid salt restriction and ammonium chloride orally, this was controlled. At this time she started taking liquid cortisone orally and at a later date in the pill form. Since August 1950, she has been on an average daily dose of 67.5 milligrams. Her course has been one of almost continuous remission except for several short periods in which an attempt was made to reduce the dosage. These were controlled by several days of increased dosage. Repeated laboratory observations have been within normal limits. Complications have been absent except for a phlebitis of the left calf during the early phase of therapy. She has been asymptomatic and has also noted marked improvement of osteoarthritic symptoms of the spine and fingers. She is more active than in prior years and is happy with this form of therapy. At this date (October 1951), 18 months after starting therapy, she continues on a maintenance dose. Her total cortisone to date is approximately 38 Grams. The effect in this case is excellent clinically and a continuation of prolonged administration is contemplated because of her age and the severity of the disease. This case further exemplifies the problem of maintenance doses and the handling of temporary recurrences. Furthermore, it illustrates some of the complications and problems of continued administration.

4. Freyberg, R. H., *et al.*: Annals of Rheumatic Diseases, 10:1 (1951).

In all cases where prolonged administration is contemplated, the patient must understand and accept several conditions as follows:

1. Indefinite administration.
2. The financial burden.
3. Continuous clinical and laboratory observation.
4. The danger of side effects.
5. The possibility of permanent harmful effects in the future.

Thus this method has many drawbacks, but still has merits within the limitations listed above. Only future studies will determine the usefulness of this method.

PROLONGED SLOW WITHDRAWAL

In the usual plan of administration of cortisone, the drug is given for a period of time on a maintenance dosage basis. Following this, cortisone is stopped fairly promptly by reducing the dosage proportionately every few days, reaching complete cessation within a week or two. This is unsatisfactory because of: rapid recurrence of symptoms; the intensity of symptoms; the withdrawal state and the marked psychologic trauma. To circumvent many of these drawbacks, I have tried various plans of withdrawal of the drug. On the basis of experience with a small group of patients, I am convinced that the following method will produce a minimum of withdrawal symptoms without the severity seen in other methods. Furthermore the symptoms recur slowly and insidiously so that the patient readjusts to his complaints without the severe psychologic upheaval seen in the rapid withdrawal method. However, it must be emphasized that to date this method has not achieved lasting remissions. In each case there has been a recurrence of symptoms although at present, two cases in this small series show promise of maintaining a fair ratio of improvement.

The method used is as follows. After the preliminary administration reaching a state of clinical remission, there is a gradual reduction of dosage during a period of five or six weeks to complete cessation. This is illustrated in the following table:

TABLE I

1st day	200 to 300 milligrams
2nd day	100 to 200 milligrams
3rd to 10th day	100 milligrams
11th day	87.5 milligrams
12th day	100 milligrams
13th day	87.5 milligrams
14th day	100 milligrams
15th day	87.5 milligrams
16th day	87.5 milligrams
17th day	87.5 milligrams
18th day	75 milligrams
19th day	87.5 milligrams
20th day	75 milligrams
4th week	75 milligrams
5th week	alternate 75 and 62.5 milligrams
6th week	alternate 62.5 and 50 milligrams
7th week	alternate 50 and 37.5 milligrams
8th week	37.5 milligrams daily
9th week	alternate 37.5 and 25 milligrams
10th week	25 milligrams daily
11th week	alternate 25 and 12.5 milligrams
12th week	12.5 milligrams daily
13th week	12.5 milligrams on alternate days
14th week	discontinue

The cortisone is given orally in divided doses. At the lower levels of dosage, the drug is given in half tablet divisions, spread throughout the day. Note that there is a slow continuous reduction of dosage from the early period of clinical improvement. This may be varied by prolonging the maintenance period for varying intervals before commencing the stage of slow withdrawal.

Symptoms usually begin to recur in the seventh or eighth week and gradually continue to a greater degree by the end of the course when there is a recurrence of all or part of the symptoms. The following case report exhibits the effects of this method of administration.

CASE REPORT

A 60 year old female had an eleven year history of chronic deforming joint changes particularly of the hands, wrists, elbows and shoulders. When seen in May 1951, she presented flexion deformities of the hands and elbows. There was limitation of movements of the shoulder. Both knees exhibited limited flexion and extension, with difficulty in walking or all activities. Previous therapy had been of little value. Because of the marked changes, she was started on cortisone in an attempt to correct the deformities. The course of therapy was that outlined above. This was administered without any ill effects. All laboratory findings were normal. She showed very mild symptomatic improvement but there was no effect on the deformities. At this time the drug has been discontinued without harmful or symptomatic difficulties.

In this case the drug was given in an attempt to correct chronic deformities of a long-standing rheumatoid arthritis. Clinical improvement was slight but little emotional upheaval or aggravation of symptoms resulted from the cortisone. As will be pointed out in a later paper, the use of cortisone in any plan of administration must not follow a routine pattern. It should be given for *definite* indications. That alone will prevent most of the harmful effects or poor results noted during the course of routinized therapy.

GOLD AND CORTISONE COMBINED

The lack of permanent effects from cortisone therapy early led to a search for methods of prolonging the effects of the drug and producing a lasting remission. Various combinations of drugs have been used with cortisone.[3] These include insulin, pregnenolone, estrogens, testosterone and others. Recently several groups of investigators[5] have reported on the combined use of gold and cortisone[6] with variable results. For the past few months, I have treated a small group of patients in this fashion, and on the basis of these results feel there is enough encouragement to continue this method of treatment.

This combination seems a logical sequence in the development of approaches to the treatment of rheumatoid arthritis. Until recently, gold was recognized by most clinicians as the most effective drug in the therapy of the arthritis particularly in the early phase of the disease. The improvement is slow but, when achieved, is satisfactory in from 40 to 75 per cent of the cases. However, it usually takes up to two months before clinical improvement begins. Purpose of this combination is to produce a rapid clinical remission with cortisone. The drugs are given concurrently, using 50 milligrams of the gold salt* until one Gram has accumulated. The cortisone is given according to the pattern outlined in the table above. Gradual withdrawal of the cortisone is attained after 10 to 14 weeks. By this

* The gold preparation used was "Solganol" a product of the Schering Corporation. It is a form of auro-thio-glucose containing 50 per cent gold in oil suspension.

5. Bilko, P. J., and Cader, G.: Postgraduate Medicine, 9:3 (1951).

6. Margolis, H. M., and Caplan, P. S.: In Proceedings of Second Clinical ACTH Conference, Volume II, first edition. Philadelphia, Blakiston Co., p. 603 (1951).

time, gold injected will have totalled about 500 milligrams, a level at which clinical improvement from gold alone begins to reach a satisfactory stage.

Thus, we produce a rapid clinical remission. When the cortisone is gradually withdrawn, the gold produces its usual effects, taking over and maintaining the remission indefinitely.

This method produces a continuous state of improvement with an ideally attained remission. The following case is representative of the results obtained with this small group of cases in the preliminary study.

CASE REPORT

A 56 year old white female had a one year history of progressive joint pain and swelling of the hands, wrists, knees, shoulders and feet. She exhibited typical physical findings; x-ray and laboratory results confirmed the diagnosis of rheumatoid arthritis.

She was placed on a combined regime of cortisone and gold. The dosage schedule was that described above. There was complete relief of symptoms within 24 hours after starting cortisone. The cortisone was gradually withdrawn over a period of four months while the gold was continued without interruption. The improvement was maintained after the cortisone withdrawal and continued with the gold effect up to the present (10 months after beginning treatment).

This illustrates the rapid improvement, the maintained improvement by gold after cortisone is stopped, and the excellent clinical results. This method seems to hold the greatest promise for the highest ratio of clinical remissions. Further studies are necessary to bear out this impression.

SUMMARY

1. Various methods of administering cortisone in rheumatic diseases are described.

2. Cortisone is not an effective drug in producing remission in rheumatoid arthritis after conventional and intermittent courses of therapy.

3. Prolonged administration of cortisone is an effective therapeutic agent but requires further study to determine its long-range efficacy and safety.

4. A method of slow withdrawal of cortisone is outlined. This minimizes "withdrawal effects" and rapid recurrences of symptoms.

5. A method of combined cortisone and gold therapy is described which gives good clinical improvement and maintained relief. This requires further investigation.

32 Johnson Avenue

IN MEDICAL SOCIETIES AS IN BAR ASSOciations, engineers' clubs and the United States Senate, leadership is likely to be in the hands of the older doctors, while the young practitioners sit in the back of the meeting rooms and chorus "Aye" to the Chairman's "All in favor of"—— This is fair enough, since seniority usually certifies the mellow judgment that flows from experience. But in at least one phase of medical practice, the younger doctor has a pretty realistic viewpoint. He is the man who handles most of the clinic cases and in private practice he is likely to work among a lower income group than do his seniors. From his box-seat on the economic front he can see some problems and some trends that might not be so clear to the older leaders who practiced their "charity work" in a different decade and who today circulate chiefly among the middle and upper income classes. That's why there has been a tendency in the more dynamic county medical societies to place younger men on committees. The arrangement seems not only sensible but eminently just too, since if sweeping changes are to be made in the distribution of medical care it's today's junior practitioners who are going to be the shock troops of the profession tomorrow.

THE OLD DAYS ARE ALWAYS THE GOOD ones . . . in fantasy. A patient, protesting the "high cost of medical care" remembers that granpa got medical service at the cost of a dollar a call. Yes, but what granpa got was a pulse-count and a three-ounce bottle of a "bitter tonic". Which wasn't worth more than a dollar a call. Today's patient gets an examination that uses modern, expensive equipment; receives drugs or biologicals made potent by costly research and costly preparation. The additional expense has to be reflected in the doctor's bill. You can't beat arithmetic.

♣ ♣ ♣

IT IS A GREAT INJUSTICE, PERHAPS EVEN more to the nurse than to the patient, to expect a small nurse to care for a patient who weighs two hundred fifty pounds, and is practically helpless. If the physical demands made upon the nurse by a patient are going to be great, then choose a good large nurse, of robust physique.—"Disease and the Man"—Lapham.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

The Public Health Council of the New Jersey Department of Health recently went on record as favoring abolition of the "means test" for admission of patients to public tuberculosis sanatoria.

The means test is a requirement that patients (or their responsible relatives) pay all or some portion of the costs of their care, unless they are destitute. The motion opposing this practice was approved by every member of the Council present.

Adoption of the motion was strongly urged by Dr. Marcus Newcomb, Medical Director of the Marcus W. Newcomb Hospital for Chest Diseases in Burlington County. He pointed out that most of the cost of care in public institutions is now borne by taxation; that removal of the means test would impose only a small addition to present public costs; that any temporary increase in public costs would be more than offset in a few years by the preventive benefits of the repeal of the means test; that fear of hospitalization costs keeps many ill persons from entering a sanatorium as soon as they should; that worry about the bill that is accumulating induces many patients to leave a sanatorium while their illness is communicable; that these two factors result in unnecessary spread of tuberculosis to others with consequent high costs to everybody; and that repeal of the means test for tuberculous patients has been a long step forward in the over-all control of tuberculosis in other states.

CONFERENCE ON ATMOSPHERIC POLLUTION

A two-day statewide conference and exhibit on atmospheric pollution will be held in Trenton on February 19 and 20. Purpose of this project is to familiarize public officials with the capacities and limitations of atmospheric pollution abatement methods and to familiarize industry with available methods and facilities for control of industrial air effluent.

The decision to hold the conference was made by representatives of industry, of municipal groups, and of state departments represented.

Dr. Daniel Bergsma, State Commissioner of Health, was elected general chairman. Dr. Geoffrey Esty, Director of the State Health Department's Division of Constructive Health, was namd vice-chairman; and Dr. Miriam Sachs, Chief of the Bureau on Adult and Industrial Health, was named secretary.

Organizations represented at the meeting included the New Jersey Chamber of Commerce; the New Jersey State League of Municipalities; the New Jersey Section of the American Industrial Hygiene Association; the Manufacturing Chemical Association; the American Society of Heating and Ventilating Engineers; Bituminous Coal Research, Inc.; the State Department of Conservation and Economic Development; and the State Department of Health.

BROCHURE ON TUBERCULIN TESTING

An informative brochure about tuberculin testing has been sent by the New Jersey Tubeculosis League to every local board of health, health officer, board of education, school nurse, and school physician. It is entitled: "Fundamental Facts About Tuberculin Testing in Children and High School Pupils: A Guide for School Physicians, School Administrators, and Members of Boards of Education". Copies are available from the New Jersey Tuberculosis League at 15 East Kinney Street, Newark 5, N. J.

COUNTY SOCIETY REPORTS

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

A regular monthly meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on November 8, 1951. Our President, DR. T. B. DICKSON, presided.

This was a joint meeting with the osteopaths and dentists of the County to consider *Your Role in Civilian Defense.* The program was prepared by the Medical and Health Director of the Pines Area, R. W. Betts, M.D., and his staff. In order to consider the topic in all of its phases— the state, the area and the community level—the following speakers were presented by Dr. Betts:

ARTHUR W. LEWIS, Esq., Legal Adviser to the Pines Area Staff, emphasized our need for Civil Defense and the reasons for the legislation. He made it clear that the effectiveness of the national program rests on the state and local organizations.

MR. THOMAS DIGNAN, Deputy Director of the New Jersey Department of Defense, discussed the financial aspects that have been encountered and the organization that has been accomplished by the state. The latter is directed toward mass education and formation of Civil Defense units in every town.

The Medical Department organization for Burlington County was outlined by MR. E. BUDD MARTER, III, Area Director.

MR. RICHARD GROVER, Civil Defense Director of Mt. Holly Township, noted the general organization attained to date by the local group at Mt. Holly.

Medical preparedness within the City of Burlington was described by PAUL SPARKS, M.D., the Medical and Health Director of that community. In some detail, he described a plan of organization for local medical care.

DR. MARIE SENA of the New Jersey Department of Health highlighted several aspects of the technic of medical organization and procedure detail which is fully described in the booklet entitled *New Jersey Plan for Emergency Medical and Health Preparedness,* recently published by the State Division of Civil Defense.

CAMDEN COUNTY

James P. Harbeson, M.D., Reporter

On December 4, 1951, the regular monthly meeting of the *Camden County Medical Society* was called to order by DR. WALTER A. CRIST, President.

DRS. JOSEPH M. DELUCA, ROWAN C. PEARCE, JR., ALBERT H. HELM, ORAM R. KLINE, JR., WILLIAM R. STEVENSON, MATTHEW E. JOHNSON and LUIGI A. PRINCIPATO, having been elected to full membership, were introduced to the society, after taking the oath of membership.

The scientific program consisted of a most interesting talk given by DR. JULIAN JOHNSON, professor of Surgery, University of Pennsylvania Medical School. He spoke on "Recent Advances in Thoracic Surgery", and covered phases of malignancy of the esophagus and lung, and also discussed the problems of cardiac surgery.

Members were again urged to have photographs taken for the medical society album.

Dr. Coriell announced the outcome of the essay contest conducted by the society for Public Health Week.

Red Cross Program Committee was appointed by the president, consisting of DR. GILBERT, chairman, and DRS. HARBESON, MEYER, SWIECIKI and OSBORN.

ESSEX COUNTY

Elizabeth R. Brackett, M.D., Reporter

Our second meeting of the year, held on November 8, 1951, departed somewhat from our usual custom by combining the meeting of our Medical Society with the Staff Meeting of the Presbyterian Hospital in Newark.

Our President, DR. KENNETH GARDNER, presided, and as soon as the necessary business was completed, turned the meeting over to the chairman of the Program Committee for the evening, Dr. Benjamin Saslow.

An excellent symposium on "Hypertension" was presented, illustrated with many lantern slides. DR. C. A. POINDEXTER, professor of Medicine at New York University, spoke on the "Medical Aspects" and DR. J. W. HUNTER, professor of Surgery at New York University, on the "Surgical Aspects". A general discussion followed the lectures.

The meeting was unusually well attended, about two hundred doctors being present in the Nurse's Auditorium, and many favorable comments were overheard regarding a combined meeting in different hospitals during the coming year.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

ANTHONY J. DIMARINO, M.D., presided at the November 15, 1951, meeting of the *Gloucester County Medical Society* which was held at the Woodbury Country Club.

Dr. LaRosa introduced the speaker of the evening, CHARLES C. WOLFERTH, M.D., professor of Medicine, University of Pennsylvania School of Medicine. Dr. Wolferth thoroughly covered his field in discussing "Recent Advances in the Management of Cardiovascular Diseases". Recent as well as experimental and promising measures for the future were described. Many practical questions were ably answered by our learned and interesting lecturer.

After hearing the treasurer's report from Joseph Hughes, M.D., it was decided to keep the dues at $30 for the present. Louis K. Collins, M.D., mentioned the article "I'm a Doctor—and I'm Human" from the Saturday Evening Post of November 17, suggesting that it might have good Public Relations possibilities.

In answer to a request from the State Society, a schedule of average fees was sent in.

MIDDLESEX COUNTY

Frank L. Paret, M.D., Reporter

The November 21, 1951, meeting of the *Middlesex County Medical Society,* held in Roosevelt Hospital, Metuchen, was called to order promptly at 9:00 p. m., DR. MARSHALL SMITH, President, presiding.

The Society unanimously approved the election of DRS. HAROLD V. VANO, Spotswood, EMANUEL KATZ, New Brunswick and FRANK W. PISCIOTTA, Highland Park, to Regular membership from Associate membership; and DRS. JOHN J. KANGOS, New Brunswick, EUGENE L. CHILDERS, Nixon and WALTER ZARESKI, South River to a two-year period of Associate membership.

RICHARD NEVIN, Executive Officer of The Medical Society of New Jersey, familiarized the Society with the duties of his office. He emphasized the need for unity of action through unity of purpose, particularly in the fight against socialized medicine.

On the request of Dr. D. W. Scanlan, chairman, Advisory Committee on General Practice of the State Medical Society, a postal card survey of the members will be made to determine actual costs of office, house and night calls and emergency charges to the patient.

A request by the Medical-Surgical Plan of New Jersey, for a four-man committee to sit in an advisory capacity at the forthcoming regional conference was brought to the attention of the Society by Dr. Charles F. Church, Secretary, and action taken.

Dr. B. M. Howley reported that the Annual Dinner meeting would be held at the Pines, Metuchen, on December 19. Lewis Webster Jones, Ph.D., President of Rutgers University, will be the guest speaker.

Dr. Jack E. Shangold, chairman of the committee on Public Health, reported a successful Health Week program and public turnout in Perth Amboy. Breast cancer and self-examination were stressed to a "Ladies only" audience, which was attended by 500 women. Movies, x-ray and lectures on heart and lung diseases were also presented to the public. Dr. Church stated that a similar program was executed in New Brunswick, and free blood typing and diabetes tests were urged on each visitor at the Bayard Street School.

Public Relations chairman, Dr. John S. Van Mater, summed up the year's program and related that state legislation on the Medical School has been tabled for one year. The problem of availability of physicians on Wednesdays, Saturdays and Sundays had also been thoroughly investigated and it was felt that most problems arose because of a lack of knowledge on the part of the public as to how to obtain a physician in an emergency. Towards this end, Dr. Carlyle Morris was asked to present a plan for publication as to the proper method of obtaining medical care at any time.

MONMOUTH COUNTY

Sidney M. Hodas, M.D., Reporter

The Staff of the United States Army Hospital at Fort Monmouth was host for the regular meeting of the *Monmouth County Medical Society* on October 24, 1951. A dinner was served prior to the scientific session.

The Society was greeted by Colonel Harold V. Raycroft. The speaker of the evening was DR. M. R. HILLEMAN, chief of Virus Diagnostic Laboratory and Respiratory Research Section, Army Medical Service Graduate School, Washington, D. C., who presented a paper on "Problems in Diagnosis and Prevention of Virus Respiratory Disease".

DRS. NICHOLAS J. ARCOMANO of Long Branch and JOHN R. AYRES, JR., of Red Bank, previously Associate members, were elected to Active membership.

The regular meeting of the *Monmouth County Medical Society* took place on November 28, 1951, at the Marine Grill, Asbury Park, with the President, DR. J. BERKELEY GORDON, presiding.

The program featured presentations on "Diseases of the Gall Bladder and Biliary Tract" from both a medical and surgical point of view. DR. WALTER MERSHEIMER, associate professor of Surgery, New York Medical College, Flower and Fifth Avenue Hospital, spoke on the surgical aspects of diseases of gall bladder and biliary tract. DR. J. EDWARD BERK, assistant professor of Medicine, Temple University School of Medicine, gave a talk on the "Postcholecystectomy Syndrome".

DR. RAYMOND E. JACOBUS was advanced from Associate to Active membership.

It was announced that the Holiday Dinner Dance, jointly sponsored by the County Society and the Woman's Auxiliary, will be held on December 28.

It was voted that the annual dues be continued at $50.00.

OCEAN COUNTY

Jesse Schulman, M.D., Reporter

The regular meeting of the *Ocean County Medical Society* was held on November 14, 1951, at the Old Cedar Inn, Toms River. The scientific meeting was devoted to an informal address by MR. ROBERT C. STANFILL, chief of the Philadelphia District of the Pure Food and Drug Administration, who spoke in general about the activities of his agency.

Of particular interest was the law concerning the over-the-counter-sale of prescription items and other potentially dangerous drugs. His agency is also involved in the control of the sale of certain drugs and devices whose manufacturers make false and misleading statements concerning their value. His agency exerts no influence over the manner in which these items are advertised to the public and is able to act against them only if the labels on the items are misleading. This is one of the weaknesses of the present Act and he stated that while he is not allowed to lobby for legislation, it is the opinion of many that the public would be better served if more stringent controls on advertising were available and if their enforcement was a duty of the Pure Food and Drug Administration. The society members were amazed by the fact that the Administration operates on a national budget of only $5,000,000, and has a national personnel of only 1100, including administrative, scientific, clerical, and enforcement workers.

During the business meeting a resolution recommending a more comprehensive examination of food

handlers was passed and copies sent to the Local Health Departments throughout the county.

A resolution pledging cooperation in full with the Red Cross Bloodmobile program, including individual donation of blood by members in their own communities, was adopted.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held jointly with the New Jersey Chapter of Chest Physicians at Valley View Sanatorium, Paterson, on November 20, 1951. Sandor A. Levisohn, M.D., President of the county society, presided at the meeting.

At the business session preceding the program, Paul Phillips, M.D., and Henry D. Shapiro, M.D., Paterson, were elected to Associate membership.

A resolution was read establishing the policy that "Any Associate member who is elected prior to March 15 of any year shall automatically become an Active member on January 1 of the following year and shall be billed accordingly". This resolution was passed at the regular meeting of the Welfare Council on November 19.

Homer H. Cherry, M.D., director and superintendent of Valley View Sanatorium introduced the speaker of the scientific session, Edgar Mayer, M.D., clinical professor of Medicine, New York University and Bellevue Medical Center. Dr. Mayer spoke on "The More Recent Aspects of Chronic Pulmonary Diseases" and effectively illustrated his talk with lantern slides and x-ray film.

SOMERSET COUNTY

H. E. Cook, M.D., Reporter

The first regular meeting of the *Somerset County Medical Society* for 1951-1952 was held on November 8, 1951, at the Somerset Hospital Nurses Home. Dr. Irving Klompus, the president, called the meeting to order at 8:45 p. m.

Dr. F. L. Field and Dr. Lancelot Ely were nominated as Emeritus Members of the Society and the nominations were unanimously approved.

Dr. George A. Greenberg introduced the speaker of the evening, Dr. Samuel Malamed, assistant clinical professor of Medicine at Columbia University. Dr. Malamed gave an exceedingly interesting discussion on the "Treatment of the Anemias".

Mr. Richard Nevin, Executive Officer of the State Medical Society, reported upon the activities of the State Society.

UNION COUNTY

Leslie M. Townsend, M.D., Reporter

In spite of the cold, rainy night an interested and enthusiastic group of members turned out to attend the November meeting of the *Union County Medical Society* held at the Johnson and Johnson Baby Products Division building in Cranford on November 14, 1951. The members attending were rewarded by hearing an unusually fine presentation on the "Practical Aspects of Antimicrobial Therapy" by Dr. J. Vernon Knight, director of Laboratories on Infectious Diseases and assistant visiting physician, Cornell Medical Division of Bellevue Hospital, New York, N. Y. His talk was a resume of the current status of antibiotic therapy in infectious disease and from the questions and discussion that followed it was apparent that his presentation on this timely subject had been of unusual interest to the members in attendance.

Preceding this scientific program the Society heard Mr. Addison C. Ely, director of Civil Defense for Union County, speak on "Civil Defense for Union County". Mr. Ely reminded the members of the county-wide aspects of civilian defense and of our obligation to be prepared to serve when and as needed under our own chairman, Dr. R. M. Freeman.

Dr. Norman S. Burritt, our first vice-president, presided at the business meeting following the scientific part of the program, in the absence of Dr. Louis S. Wegryn who was in San Francisco attending the annual session of the American College of Surgeons. New members, all of whom were unanimously elected, are as follows: Rita E. Ganz, Jean A. Herz, and Raymond L. Stone of Elizabeth; David C. Rodman of Plainfield; Frank Keil of South Plainfield; Joseph Kalbacher and Richard B. Maxwell, Jr. of Westfield; Edmond Kussouf of Cranford; and Milton M. Mazursky of Roselle.

NEW JERSEY ACADEMY OF GENERAL PRACTICE

Aaron H. Horland, M.D., Reporter

The *New Jersey Chapter of the American Academy of General Practice* held its third annual meeting on December 9, 1951, in Trenton.

Dr. Aaron H. Horland, Newark, introduced a resolution which was unanimously passed, endorsing the New Jersey Plan of Health Insurance developed by The Medical Society of New Jersey. This plan assures adequate medical care to all segments of our population using allocated government funds.

The action taken by this group will be brought before the House of Delegates of the American Medical Association at its next convention in Atlantic City. At the present time the A.M.A. is studying the New Jersey Plan with the view toward adopting it as organized medicine's answer to compulsory health insurance.

Dr. Aaron H. Horland, the immediate past-president, presented Dr. Sidney D. Becker of Keyport, the retiring president, with a plaque and a gold key making him a fellow of the Academy. Dr. Theodore M. Silverman of Elizabeth was inducted as president and the following officers were elected: President-Elect, Dr. Edwin Bosner, Collingswood; Vice-President, Dr. Vincent Campana, Jersey City; Secretary-Treasurer, Dr. Arthur Trewhella, Jersey City.

Dr. Samuel Garlan, President of the New York Academy of General Practice, was the principal speaker. He stressed the importance of every family having its own family physician and made a plea for the development of postgraduate programs so that better general practitioners could be trained in the future.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Thomas H. McGlade, West Collingswood

It is my hope that you have all had a very Happy Holiday Season and are now eager to start the New Year with enthusiasm and determination to make the year 1952 another one of progress for the Auxiliary.

Recently, Mrs. Dyer and I attended the National Auxiliary Conference in Chicago, where we heard Dr. Ernest B. Howard stress the importance of choosing the right candidate during this election year. All three Conference speakers suggested we must be interested and should play an active part in politics. We assume community responsibility when we become the wives of physicians. The Civil Defense Chairman, at the National Conference, urged the furtherance of the Blood Program. Seventy per cent of the blood used in Korea was given by the soldiers. Surely here is an opportunity for Auxiliary members to play an important part in a most vital program. We could have an Auxiliary Blood Donor Day and induce our friends to participate with us.

This is our Silver Anniversary Year. Not only is the state organization celebrating its twenty-fifth year, but according to reports that I have received, Burlington, Camden, Essex, Gloucester, Hudson, Passaic, and Union Counties were also organized in 1927. The membership in these counties, upon organization, was approximately one hundred sixty members and it has increased to the present number of over twelve hundred. You are well aware of our accomplishments during these past twenty-five years. We hope to highlight them at our Convention in May.

NATIONAL CONFERENCE

The 1951 conference of state presidents and presidents-elect and national standing committee chairmen was held in Chicago on November 14 and 15, 1951. The theme was "Working Together for Health". The number of those registered was 86 persons from 46 states and the District of Columbia.

Mrs. Harold F. Waldquist, President, called the conference to order and welcomed those present. In her report Mrs. Walquist said we have had a tooling-up period and now our job is "to awake the laity to the great part the A.M.A. is playing in the health of the nation". She quoted our past national president, Mrs. David B. Allman, in saying we are "coming together, working together, and staying together". The Auxiliary has at present 58,147 members and it is the aim to add 10,000 more. She said we must have local planning and action to fit local needs. She reminded us that medicine knows no language race or creed and that no group has contributed more to the American way of life.

Dr. Ernest B. Howard, Assistant Secretary, A.M.A. spoke on the "Projects of the A.M.A." using slides to show us the workings of the organization. He spoke of the new A.M.A. handbook and urged that the doctors make more use of the facilties of the Chicago office, that they be alert in 1952 to developments in the coming elections. He said, "Our biggest job is to see that basic ideas of free enterprise are carried forward".

Mrs. Ralph Eusden, President-Elect and Conference Chairman opened the panel discussions.

Organization—Mrs. Leo J. Schaefer, Chairman. Participants: Illinois, Rhode Island and Montana State Presidents. Organization and membership are the cornerstone of the Auxiliary. There are 83,000 eligible women as potential new members and of these we hope to enroll 10,000 as new members this year. Members-at-large are a nucleus for forming a new Auxiliary. Only interested women make a strong Auxiliary, and as this is the only organization working for your husbands' interests, it should be your first consideration. Auxiliary members should share ideas, give credit for achievements, and practice teamwork. "Show courtesy and reap friendship."

Finance—Mrs. Truman Caylor, Chairman. Participants: District of Columbia, North Dakota, South Carolina, Vermont, New Mexico State Presi-

dents. Chairmen must notify each chairman of the amount of money to be received, and also when the money is almost gone. They should use vouchers and check bills by number of the voucher. The annual report should contain plans for the next year and allow 10 per cent for a contingent fund. Vouchers should be made in triplicate, made to the person for whom the check is intended and sent in quarterly, except for travel vouchers which should be sent in every thirty days. The state treasurer follows the records sent to her. The fiscal year for National ends July 1, and March 1 is the deadline for the national treasurer. Bills for dues might be sent out by the treasurer in a self-addressed envelope. It is suggested that books be audited by a C.P.A.

Nurse Recruitment—Mrs. Theodore E. Heinz, Public Relations, Moderator. Participants: Colorado, Idaho, Iowa, Louisiana, Michigan, New York, Nebraska, and Ohio State Presidents. Film showing: "Girls in White". A survey has been made of nursing and hospital facilties in the states. Chairmen should organize state, county and community Speakers' Bureaus, Health Days, approach school guidance counsellors and distribute literature on the nursing opportunities. The Iowa plan: The Future Nurses Club of America in high schools open to juniors and seniors. Members of the faculty serve as advisers, they meet on school time, have talks by graduate nurses, reports on schools of nursing, talks by doctors, visits to the blood bank, a round-table with student nurses, give radio talks, see films. A good pamphlet: We Are Glad Our Daughter Is Going to Become a Nurse. A loose-leaf notebook might be placed in the schools giving general information on the different schools of nursing. A skit for high schools was suggested by the Michigan State Society—"Planning Your Career". Colorado has a questionnaire to be sent to organizations about starting a nursing scholarship.

Today's Health — Mrs. J. K. Avent, Chairman. Participants: North Carolina and Washington State Presidents. Copies of *Today's Health* were mailed from the conference by individual members to persons in foreign countries. Additional issues will be sent if requested by those persons. The editors are anxious to receive comments on how the magazine might be improved. Dentists should subscribe to it. We must make a concerted drive to get this magazine into the hands of the public.

Community Service—Mrs. Arthur A. Herrold. National Past President, Moderator. Participants: Arizona, Alabama, California, Kansas, Kentucky, New Jersey, West Virginia State Presidents. Rearing our children well is a community service. Individual indifference undoes more than much of the good we do. We must gain the confidence of others. Our county programs need improving. Suggested: Radio Quiz Program—University of Texas (Radio Kits). This must be started the preceding January, presenting your ideas to the school superintendent, asking the cooperation of local social agencies and guest experts. The Homemakers Service plan was suggested and explained as worked out in a New Jersey Auxiliary.

Health Days—Mrs. Alfred Burnside. Program Chairman. Participants: Arkansas, Connecticut, Indiana, Minnesota, Nevada, South Dakota, Wisconsin State Presidents. Health days were started in Minnesota in 1948. They should be a community wide program, designed to educate the public to their health problems. Indiana has considered organizing a state health council after successfully organizing their county councils. Careful planning and much publicity is needed before these programs are presented.

Handbook — Mrs. Leo J. Schaefer, Chairman. The handbook is being revised and modernized and should be a great help to all active Auxiliary members.

Civil Defense—We are urged to register with our local civil defense office as to special abilities or as general helpers, take a First Aid course, help with the Red Cross Blood Program and make a file of members' qualifications. New Jersey was mentioned for the good work done in First Aid. Texas has a television program on home-nursing in event of atomic attack. Russia has 22,000,000 persons trained in Civil Defense work. Seventy per cent of the blood used in Korea was given by the soldiers themselves.

Legislation — Mrs. Edgar E. Quayle, Chairman. Participants: Georgia, Maryland, Mississippi, Oklahoma, Oregon and Pennsylvania State Presidents. Socialized medicine will be a political issue in 1952. Politics must become our business and we must use our vote as a safeguard. Bills to watch: HR54—may be brought back; HR274—A.M.A. recommended modifications; S337—about scholarship grants, government subsidizing is dangerous; HR4322—School Health Services under Federal Security Administration; S1245—maternal benefits for wives and infants of servicemen.

Publication—Mrs. James P. Simonds, Chairman. Participants: Mrs. David B. Allman, Chairman of Bulletin Circulation, Florida, Maine, Missouri and Utah State Presidents. The *Bulletin* chairman aims at 10,000 new subscriptions. Please use envelopes to be sent to state chairmen to be distributed to county *Bulletin* chairmen. It is suggested that copies of *Bulletin* be kept on file as a good reference. Only a little over 10 per cent of membership subscribe to the *Bulletin.* Many states now have their own publications which are proving valuable in keeping their membership informed.

Historian—Mrs. Jesse Hamer. The work of the historian is to summarize your year's work. It is important to keep these records complete.

Summary—Mrs. Ralph Eusden, Conference Chairman. The conference chairman stressed the following points: organization is the foundation of the activities on which the Auxiliary rests; the value of schools of instruction for chairmen and committees; the personal relationship dividend gained in the Auxiliary; that every action is a reflection, good or bad on our medical society; that nurse recruitment belongs to the public and we must stimulate public interest in it; that *Today's Health* offers authoritative information to the public and to our schools; that we accept our civic obligation and render some community service; that it is our duty to leave the world in an improved condition; that Health Days offer a chance to cooperate in community endeavor.

Your State President has brought back from the Conference a number of pamphlets and helpful literature for the various chairmen. These are on file in the central office or will be distributed at the next state board meeting.

MRS. EDWARD H. DYER,
President-Elect.

AUXILIARY REPORTS

Bergen County

Mrs. Winton Johnson,
Chairman, Press and Publicity

The annual dinner-dance of the *Woman's Auxiliary to the Bergen County Medical Society* was held on December 8, 1951, at the Chimes Restaurant in Paramus, with approximately one hundred persons in attendance. Mrs. Elbert Hagovsky of Carlstadt, chairman of the event, deserves very special commendation for arranging the details of the evening. Mrs. Hagovsky and the Auxiliary President, Mrs. Thomas Garrett, together with the committee members of the evening greeted the arriving guests and performed any required introductions to assure sociability among the representatives from our various hospitals in this county. A delicious dinner and community singing added to the enjoyment of all. The orchestra provided music for the dancing which followed. The committee members were Mrs. Albert Hagovsky, Chairman; Mrs. Charles D'Amata, Mrs. Orlin Wry, Mrs. Frederick Muller, Mrs. D. M. Mayer, Mrs. Joseph Basralian, and Mrs. L. Cartnick.

The next meeting of the Auxiliary will be held on the evening of January 8, 1952, at Bergen Pines Hospital, with a speaker from the FBI discussing "Narcotics and Their Effect on Society".

Essex County

Mrs. Louis L. Covino,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held their annual Public Relations Day at the Academy of Medicine in Newark, on November 28, 1951. The program was a Symposium on Nurse Recruitment. The urgent need for more nurses in many fields and the variety of opportunities in the nursing profession were emphasized. Key people in industry, education, nursing, public health, P.T.A.'s and church groups were guests of the Auxiliary at a tea preceding the program. Also present at the tea were two student nurses, in uniform, from each Training School in Essex County.

Frank Forte, M.D., Public Relations chairman of the Essex County Medical Society, was the moderator. Mr. Herbert Meyer, secretary of the Essex County Nurse Recruitment Committee, discussed the "Practical Nurse", and Miriam A. Dailey, R.N., director, Montclair Public Health Nursing Service, covered the subject very well on "The Public Health Nurse". Ann Carstensen, winner of the first Nurse Scholarship Award given by our Auxiliary, was an inspiration in her student nurse uniform as she gave an interesting description of the "Hospital Nurse". Ann Murphy, R.N., M.A., director, School of Nursing, Jersey City Medical Center, spoke on "The College Graduate" and Ella V. Stonsby, R.N., M.A., director, Department of Nursing Education, Rutgers University, discussed "The Basic Collegiate Program in Nursing". Elizabeth Brackett, M.D., chairman of the Nursing Education Committee of the Essex County Medical Society, addressed the group on "The Physician". Edna M. Antrobus, R.N., M.A., executive secretary to the New Jersey Board of Nursing, was the guest speaker during the question and answer period that followed.

Mrs. George Parell, Public Relations chairman and Mrs. Frank Bellucci, her co-chairman, assisted by a very capable committee, did a splendid job on presenting this timely subject.

Also in November we were fortunate to have our Auxiliary in the spotlight on Radio and Television. Mrs. John Torppey, our president, Ann Carstensen, Nurse Scholarship Award winner and Mrs. P. Santora, chairman of Nurse Recruitment, gave our Public Relations Day very good advance publicity via the air waves.

Gloucester County

Mrs. Chester I. Ulmer, Publicity Chairman

Mrs. Thomas H. McGlade, our state president, and Mrs. Edward H. Dyer, our president-elect, were the guests of honor at a tea given on December 6, 1951, at the home of Mrs. Paul M. Pegau of Woodbury.

Our president, Mrs. John Laurusonis, graciously presented the State Officers to those present. The address of Mrs. McGlade was very informative and given in a delightful manner. Echoes of the recent A.M.A. Auxiliary Conference in Chicago were presented, bringing us up to date on some of the achievements of the various State Auxiliaries and the plans of the Auxiliary at top level. Mrs. McGlade stated that New Jersey, by comparison with the other State Auxiliaries, made an excellent showing. There was an informal discussion period that followed which proved additionally helpful to our group. Mrs. Dyer then spoke a few well chosen words to us.

An announcement was made of our year's project which was adopted at the September luncheon meeting, namely, Civil Defense. Mrs. Don B. Weems of Wenonah had been appointed chairman with three other members completing the committee—Mrs. Clarence A. Bowersox, Mrs. William G. Harris and Mrs. J. Earl Wentzell. All four of the members are authorized instructors in Home Nursing. One feature of the project is to publicize these courses given in various parts of the county and to obtain sponsors for future ones.

Hudson County

Mrs. Sydney Chayes, Chairman of Publicity

The *Auxiliary to the Hudson County Medical Society* of which Mrs. Morris Bresev is president, held a Christmas luncheon on December 3, 1951, at Bruno's Restaurant, Jersey City. Mrs. Michael Cerchio and Mrs. Joseph Giannasio were hostesses of the day.

Mrs. Irving Dershewitz, Program chairman, introduced Mrs. Marie Shepherd who presented "Singing Through the Holidays". Her songs portrayed The Nativity, Hanukkah—The Feast of Lights and Holiday Merrymaking.

The Auxiliary members and their guests attended a performance of "Two On the Aisle", in New York City. Mrs. Albert Lepis and Mrs. Fred Sachs were chairmen for this event sponsored for the Nursing Scholarship Fund.

Mercer County

Mrs. Raymond E. Miller,
Chairman, Press and Publicity

The Christmas meeting and party of the *Woman's Auxiliary to the Mercer County Medical Society* was held on December 5, 1951, at the Medical Society Building in Trenton. Following the dessert a brief business meeting was conducted by the president, Mrs. Charles C. Cohan. An exchange of gifts was an outstanding feature of the party. Hostesses for the occasion were Mrs. Charles C. Cohan, Mrs. C. Chester Chianese, Mrs. Sydney Fine, Mrs. Raymond E. Miller, Mrs. Felix Frisch, Mrs. Frank F. Commini, Mrs. William P. McCarthy and Mrs. W. R. Peterson. Safety posters were displayed at the meeting and Christmas Carols were played.

Middlesex County

Mrs. Louis Krafchik, Publicity Chairman

In order to stimulate the recruitment of nurses, the *Auxiliary to the Middlesex County Medical Society* will sponsor an essay contest for all high school seniors throughout the county. The subject will be "How I Can Benefit My Community by Becoming a Nurse". Dr. Harry Haywood of New Brunswick will donate the first prize of $25.00. Mrs. Edward Jasionowski of Sayreville is chairman of this project.

The Auxiliary held its regular meeting on November 28, 1951, in the home of Mrs. Benjamin Copleman in Perth Amboy, with Mrs. Norman Rosenberg presiding. Plans were made to assist as hostesses at the U.S.O. in this city under the direction of Mrs. Louis Krafchik and Mrs. Michael Brody.

The group was addressed by Dr. Abram Van Horn, director of the Kate Macy Ladd Convalescent Home in Far Hills, N. J. He described the purpose of the home and showed colored slides of the place.

Monmouth County

Mrs. Donald Bowne,
Chairman, Press and Publicity

On November 27, 1951, the *Woman's Auxiliary to the Monmouth County Medical Society* held a Membership Dessert Bridge at the Auxiliary Hall in Long Branch. Mrs. Norman Thetford was hostess. The business meeting was dispensed with in order to allow full time for the members to become better acquainted. The Auxiliary, as a member of the Woman's Division of the Monmouth County Safety Council, helped to decorate the window of a Red Bank store, illustrating ideas for a safer Christmas.

Ocean County

Mrs. Gorman Jaffee,
Chairman, Press and Publicity

The second meeting of the *Woman's Auxiliary to the Ocean County Medical Society* was held at the home of Mrs. Clinton Schneider on November 14, 1951. Mrs. Clarence B. Whims, state chairman of nurse recruitment, was the guest speaker. She stated that nursing has been placed upon the list of critical occupations by the U. S. Department of Labor. Careful planning so that sound nursing service will be widely used and distributed therefore becomes of utmost importance to national security. To fill the nursing shortage one out of ten high school graduates must become nurses. Mrs. Whims stressed the importance of acqainting the public with this situation. Following the meeting refreshments were served and everyone enjoyed an interesting meeting.

Somerset County

Mrs. Lewis C. Fritts, Publicity Chairman

The *Woman's Auxiliary to the Somerset County Medical Society* held its opening meeting of the 1951-52 season at the Far Hills Inn, Somerville, September 17, 1951. The business meeting was conducted by Mrs. John Spaido, President.

The October 17 meeting was held at the home of Mrs. Harold Wender, South Bound Brook. Mrs. Spaldo appointed the following committee chairmen: Historian—Mrs. A. P. Gewanter; Press and Publicity—Mrs. Lewis C. Fritts; Public Relations—Mrs. Martin Tolomeo; Program and Hospitality—Mrs. John Patten; Membership—Mrs. George Greenberg; Today's Health—Mrs. Bart Rossi; Health Education—Mrs. Marcus Sanford; Parliamentarian—Mrs. Irving Klompus; Safety—Mrs. Julius Galgozcy; Legislation—Mrs. Nicholas Demy; Ways and Means—Mrs. Scott McKinley.

Tentative plans were made for our annual dinner dance in January and for an auction sale to be held in the Spring.

A membership tea was held on November 21 at the home of Mrs. Lewis C. Fritts, Somerville, and took the place of our regular November meeting.

BOOK REVIEWS

Principles and Practice of Obstetrics. (Originally by Joseph B. DeLee) 10th ed., by J. P. Greenhill. Pp. 1020; with 1140 illustrations. Philadelphia, W. B. Saunders Company, 1951. ($12.00)

This textbook is so well-known and accepted that further praise is not needed. Certain chapters, in their revision and incorporation of additional material, require mention. Proper emphasis has been given to some features of *prenatal care*. The intelligent use of abdominal supports should not be neglected. Carefully selected and approved methods of exercises are highly recommended. As to the use of *caudal anesthesia*, the author states: "there is no need to employ it for the average woman in labor".

The chapter entitled "Psychology of pregnancy, labor and puerperium", written by Helene Deutsch, is excellent and shows very clearly that there is no proper approach to obstetrics and gynecology without understanding of the underlying psychologic factors and the discriminating use of psychotherapeutic methods. Dr. Greenhill mentions that hypnosis has been used in obstetrics for a long time and that it should be employed more often. With respect to hyperemesis gravidarum the author writes that psychotherapeutic treatment, particularly hypnosis, should be tried and that frequently good results are obtained. Obstetricians generally will agree with these recommendations.

B. LIEGNER, M.D.

Master Your Mind. Samuel Kahn, M.D. Rockport Press, New York, 1951. Pp. 262.

If a child is negativistic, you reason with him. "No screaming, threats or fright". That's what it says on page 235. If that doesn't work, "give him two or three lashes with a strap across his rear". So it is written on page 237. This gives some idea of the usefulness of this book in child guidance. But the volume embraces much more than child guidance. It also tells you how to study. Here's how: "know your terms; understand and evaluate; make diagrams, analyze, apply and remember". If you want to learn how to remember, there is a chapter on that too. You do things, you observe, you concentrate and you use mnemonic devices. You are also given such valuable advice as: be calm; be self-confident; see the facts as they are, and many other refreshingly new gems of wisdom. There is a section on how to use a library. A paragraph is devoted to reasons for wanting to be a good student. It opens with this earth-shaking observation: "It is advisable to be a good student for many reasons". At one point, Dr. Kahn lists "difficulties which lie in the way of effective studying". Know what the number one difficulty is? Defective intelligence! That's what he says: right on page 39.

Chapter 4 is modestly called "Valuable Advice to Students". Advice number 5 is: do not spend too much time in the bathroom. Advice number 6 is: take one or two baths a day. Had enough?

HERBERT BOEHM, M.D.

Statistics for Medical Students and Investigators in the Clinical and Biological Sciences. F. J. Moore, M.D., F. B. Cramer, B.A., and R. G. Knowles, M.S. Blakiston, 1951, Philadelphia. Pp. 114. ($3.25)

The medical student who understands binomial theorem, and who is already at home among standard deviations, probable errors, coefficients of correlation and the probit method will have no difficulty at all with this learned volume. But it is necessary to warn the reader that unless he can already calculate how many standard deviations from the mean a value is, he will be lost among these pages. The authors are skillful in presenting their material in involved language so that otherwise simple concepts become bewildering. For example, a medical student might, conceivably, be vague about the concept of "normal distribution". Now this is an idea which *can* be expressed with clarity and simplicity. But not here. The authors assume, apparently, that every college graduate already knows what a normal distribution is. So they tell us that it "is defined by two constants: the mean, its measure of central tendency, and the standard deviation, its measure of dispersion. . . When a distribution is called 'normal' this means that the data are consistent with the normal frequency distribution." Unless medical students have changed considerably since my day, the average student will not be helped by this kind of clarification.

For those who come already equipped with a good basic knowledge of statistical theory, however, the volume is a valuable one because it focusses so sharply on the technics and material of the biological sciences.

ULYSSES M. FRANK, M.D.

Proceedings of the International Society of Hematology, Third International Congress, Cambridge, England, 1950. Edited by Carl V. Moore, M.D. Pp. 600. New York, Grune and Stratton, 1951. ($10.00)

This is a report of the Third Congress of the International Society of Hematology which, in common with other international societies, includes not only those particularly interested in hematology but also those geneticists, immunologists, etc., whose work and studies concern, in some way, the broad field of hematology.

The papers have been grouped into five sections: anemias, immunohematology, leukemia, coagulation and purpura, and miscellaneous papers. The volume presents 176 actually reviewed papers, many published in entirety, and others as brief abstracts. There are 260 well reproduced illustrations. The whole is excellently printed and bound in typical Grune and Stratton manner. Every major phase of hematology has been covered. Some papers are original observations and concepts, whereas others are new interpretations of previously recognized phenomena. Several are presented in the original language with a brief English summary.

The volume is an important contribution to

hematologic literature and completely carries out the Society's mission of providing a means of free exchange of scientific information. It brings together in one place and presents in a convenient manner knowledge and information from many places that would ordinarily not be available. Great credit must be given to the officers of the Society and to the editors for their ambitious designs, and above all to the publishers for their courageous investment.

MURRAY W. SHULMAN, M.D.

Good Food Without Salt. By Margaret Vaughn. Pp. 188. New York, Thomas Y. Crowell Company, 1951. ($3.00)

The material presented in this book presumes a fundamental knowledge of general nutrition. It is written for patients and describes in detail recipes for low-sodium foods. The recipes are practical, palatable, and common to most people. Miss Vaughn is certainly well informed in information for food preparation. The organization of the material and, the recipes are done in an excellent manner.

While this book is of little value to the average practicing physician, it is one that every doctor can recommend to the patient who is compelled to be on a salt-free diet.

S. WILLIAM KALB, M.D.

Clinical and Roentgenologic Evaluation of the Pelvis in Obstetrics. By Howard C. Moloy, M.D. Pp. 119. Phila., W. B. Saunders Company, 1951. ($2.50) (American Monograph series $1.00)

This monograph represents the cumulative experience over two decades of the author who with the late Dr. William Caldwell was among the first to bring the use of the x-ray to bear on the problems of difficult labor in obstetrics. Their work led to one of the most monumental contributions to modern obstetrics, namely, a new classification of the female pelvis based on pelvic morphology, and the development of stereoroentgenometry. The combination of morphologic classification and precision measurement of the pelvic diameters by x-ray should enable the obstetrician to anticipate cephalopelvic disproportion and to predict the outcome of a difficult labor.

The author clearly and concisely reviews the anatomical variations of the pelvis, presents a complete classification of pelvic types, correlates the normal and abnormal mechanisms of labor to pelvic types, outlines many aids in the use of the forceps, and describes various roentgenologic methods for the quantitative estimation of cephalopelvic disproportion. The monograph is intended for the clinician who must manage the difficult labor. It succeeds admirably in bridging the gap between the use of clinical judgment alone and the most modern technics in obstetrics.

This is the first of a series of monographs intended to bring to the profession the practical results of research in special fields of medicine. The publishers are to be congratulated in fulfilling to the letter their intention of producing this book inexpensively and still obtaining excellence of illustration and legibility of type.

ARTHUR C. KRAGEN, M.D.

Clinical Sonnets. By Merrill Moore, M.D. New York, Twayne Publishers, Inc. Pp. 75. Ed. 4. 1951. ($2.50)

Time was when a regular sonnet had a rhyme scheme that always was rigid. It had 14 short lines written on it (or the critics became very frigid). But the form soon developed sclerosis: the sonnet was fading for sure. It was saved from a budding psychosis by the art of a doctor named Moore. In five dozen neat little stories, he pictures a covey of patients: their foibles, their fears and their glories; their relatives, friends and relations. Here's a study of mankind and man—an anatomy Gray never knew. Start reading, and stop if you can—before you have read the book through. This poet can limn from the living. His humor comes in with a bite. He's mordant and cruel—yet forgiving. And generally speaking, he's right.

HENRY A. DAVIDSON, M.D.

Atlas of Genito-Urinary Surgery. By Philip R. Roen, M.D. Illus. by Charles Stern. Pp. 325. New York, Appleton-Century Crofts, Inc., 1951. ($8.00)

This Atlas presents each operation in steps with a clear drawing on the page to the right. All the drawings are original and are easy to follow. The language accompanying the illustrations is simple, brief and clear. Many newer procedures in adrenal surgery and retropubic prostatectomy are included in the list. All operations of the genito-urinary tract are described in the atlas. This book is an invaluable addition to the library of the resident or the young urologist.

IRVING MAISEL, M.D.

From a Doctor's Heart. By Eugene F. Snyder, M.D. With a foreword by Paul Dudley White, M.D. Pp. 251. New York, Philosophical Library, 1951. ($3.75)

This book, written largely in the form of a discussion between the author, his wife (also a physician), and their teen-age son, narrates the narrow escape from death by the author from a coronary thrombosis, the Number 1 killer of the middle-aged. Stricken at the age of 49, Dr. Snyder courageously faces up to the adjustments required of a patient whose heart muscle has been organically damaged. Aided by his wife, he attempts to answer their son's probing questions about the heart anatomically and its diseased states clinically. The writing is altogether on the lay level. The book contains some autobiographic data on Dr. Snyder's life in Russia—he lived there for the first 21 years of his life—and Czechoslovakia and in this country to which he migrated in 1939. His remarks on national, racial and political problems of the day are genuinely motivated by the desire to promote better human relationships throughout the world. Anyone interested in these problems and in the health hazards of coronary heart disease, in particular, will find this a moving document of optimism and great faith.

HAROLD M. GOETTEL

Volume 49
Number 1

TUBERCULOSIS

ABSTRACTS

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV January, 1952 No. 1

CHEST X-RAYS ON ADMISSION PAY OFF

William Siegal, M.D., Robert E. Plunkett, M.D., and Herman E. Hilleboe, M.D., The Modern Hospital, July, 1951.

Routine chest X-ray examination of patients admitted to general hospitals is a fruitful method of finding new cases of pulmonary tuberculosis. The patient, the hospital staff, and the community all reap benefits. The procedure yields greater returns in discovering unsuspected disease than mass X-rays of the general population or school groups.

In New York State, outside of New York City, there are 166 voluntary, nonprofit, and publicly supported general hospitals which annually admit over 650,000 patients. The plan prepared by the New York State Department of Health and supported by public funds was developed cooperatively through the Health Department and these hospitals. Policies and procedures were set up in 1946 and briefly are as follows:

Any nonprofit general hospital with an inpatient admission rate sufficiently large to provide 4000 admission chest X-rays annually is eligible to borrow complete photofluorographic equipment for taking 4″ x 5″ or 70 mm. films. The hospital received fifty cents for each report of an admission X-ray film submitted to the local health department. The Department recommends that hospitals install equipment as close to the admitting rooms as is practicable in order to maintain a high percentage of X-rays on admitted patients.

Hospitals whose admission rate is less than 4000 patients annually may also participate in the program by using their own equipment. For this service, they receive one dollar for each X-ray report submitted. Of the 166 general hospitals, 58 are eligible for loan of photofluorographic equipment and the remaining 108 can participate by using their own equipment. The 58 hospitals eligible for loan of equipment represent only 37 per cent of all the hospitals, but account for 67 per cent of all the admissions.

Any participating general hospital, in applying to the State Health Department, agrees that it will:

1. Make every effort to X-ray the chests of *all* admitted patients, 15 years of age and over.
2. X-ray the chests of all employees not previously X-rayed and of all new employees.
3. Make no charge to the patient for the initial X-ray examination and interpretation or for additional X-rays or services necessary to establish a diagnosis of tuberculosis.
4. Use the recommended diagnostic classification.
5. Submit an X-ray report for each patient and employee examined under this program to the local health official.

It was not expected that uniform procedures for the routine X-raying of admissions would be possible for all the hospitals. The following routine, however, was suggested and is being carried out with minor changes. Identifying information is entered on a special report form at the time of admission for every patient 15 years of age or over. If possible, he is X-rayed, usually without disrobing, before being taken to his room. If he is too ill to be X-rayed on admission, this is done as soon as his physical condition permits. The admission films, 4″ x 5″, 70 mm. or 14″ x 17″, are processed and interpreted within twenty-four hours and the diagnoses, if negative or nontuberculous, are checked on a special report form.

If the admission film shows definite or suspected tuberculosis, additional chest X-ray and other examinations are made for diagnostic and clinical evaluation. The diagnosis is entered on the admission X-ray report. Completed admission X-ray reports are sent frequently to the local health officer. In addition, the hospital also furnishes the health officer with a monthly bill for the admission chest X-ray reports submitted to him. If active tuberculosis is found, the hospital then makes an official case report.

It is important that the hospitals use the same classification of disease, especially as it relates to tuberculosis, in reporting the results of these X-rays. The admission small or large film diagnosis is not considered the final diagnosis or determination of activity. Nevertheless, a tentative diagnosis is necessary in case patients do not remain in the hospital long enough for further detailed study when it is indicated. The health officer should know what persons with possible tuberculosis return to the community from the hospital. A tentative diagnosis, therefore, is made on all films. If the tentative diagnosis is definite tuberculosis, an estimate of clinical status is also made. If probably active, the extent of the disease is also noted. Films which indicate pleural effusion otherwise unexplained are considered to be probably active tuberculosis.

The follow-up of cases of definite and suspected tuberculosis found by the hospital is the health officer's responsibility. The admission X-ray reports sent to the health officer are a check on the number billed by the hospital for reimbursement; they are used also for detailed monthly reports which are sent to the State Department of Health. The health officer maintains a separate file of positive X-ray reports and arranges for follow-up examinations. These include provision for diagnostic and clinical determination for each person reported and adequate medical care. For each report of a definite or suspected case of tuberculosis, the health officer submits to the Department at the end of six months, a summary of what has happened to the person during the interval.

An analysis of the initial chest X-ray examinations of adults admitted to the general hospitals participating in this program from May 1947 to January 1950 shows that:

A total of 195,751 patients, 15 years of age and over, had chest X-rays taken on admission to 41 general hospitals. The largest number of patients examined (48 per cent of the total) was in the age group 15 to 34. Females outnumbered males two to one; the ratio of females to males was in excess of four to one between the ages 15 to 34. From the initial hospital X-ray interpretations, 3976 or 20.3 for every 1000 patients X-rayed, were tentatively diagnosed definite or suspected tuberculosis. Of these 1005 or 5.1 per 1000 X-rayed, were considered to have probably active pulmonary tuberculosis. For all ages the prevalence of probably active tuberculosis was three times as great among males as among females, the highest prevalence being in males 45 years of age and over.

The distribution of the probably active cases by stage of disease was: minimal 47 per cent, moderately advanced 35 per cent, and far advanced 18 per cent. Fewer minimal and more advanced cases are found in general hospital patients than in community surveys.

Of 126,190 admission chest X-rays during the period between January 1948 and June 1949 inclusive, 2642 showed evidence of definite or suspected tuberculosis, of which 2145 had not been previously reported and were considered new cases. Of these, 71.7 per cent received follow-up examinations within six months of the initial hospital diagnosis.

On the basis of the number diagnosed definitely active, activity undetermined and suspicious for tuberculosis after follow-up, it is estimated that, if adequate follow-up had been possible for all the 2145 new cases of definite or suspected tuberculosis, a ratio of 2.5 active cases of tuberculosis would be found for every 1000 patients X-rayed.

INVITATION

NEW JERSEY TRUDEAU SOCIETY — THIRD ANNUAL MEETING

ACADEMY OF MEDICINE, NEWARK

WEDNESDAY, APRIL 2, 1952, 8:30 P. M.

Panel Discussion:

THE PRESENT STATUS OF BCG VACCINATION

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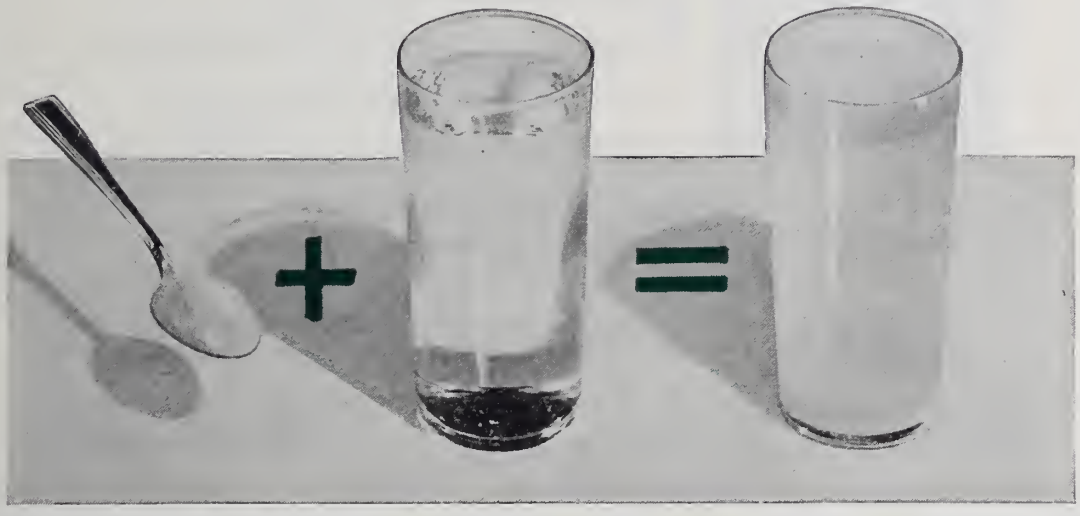
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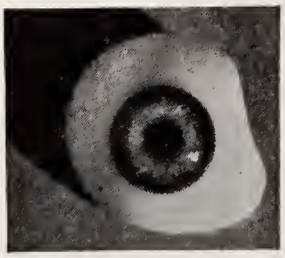
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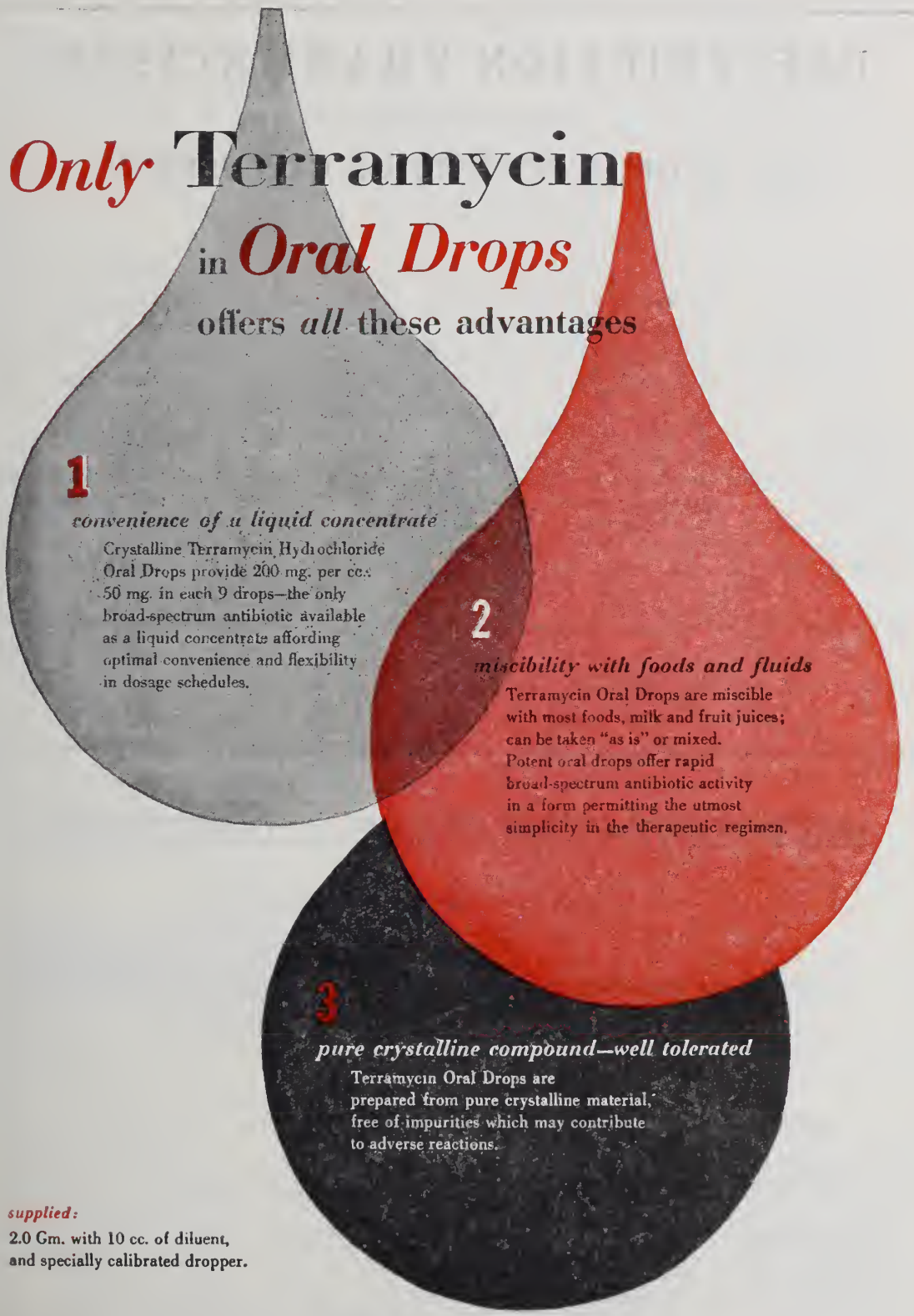
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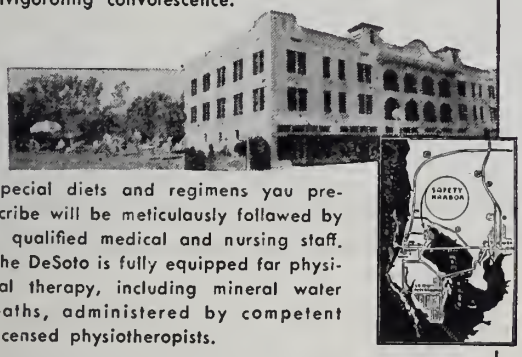
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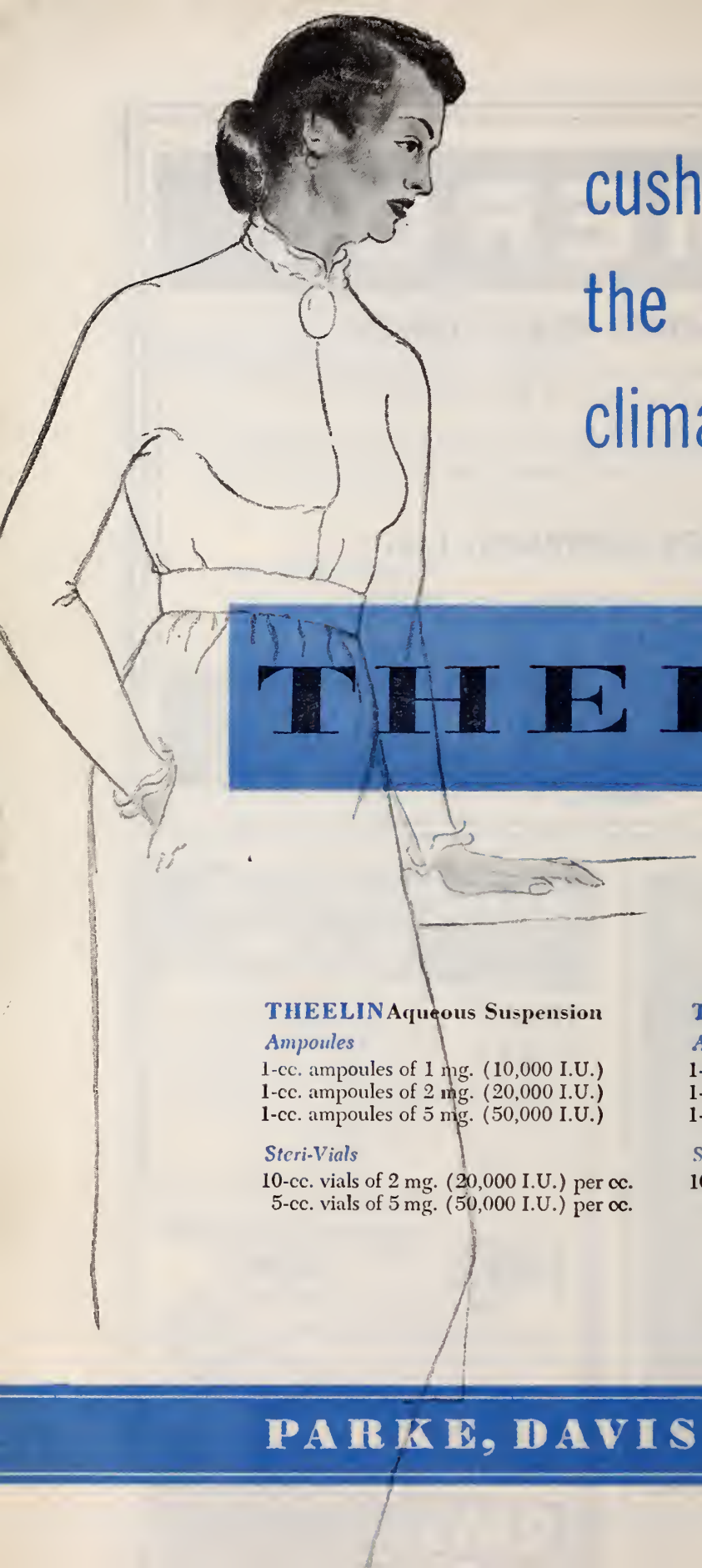


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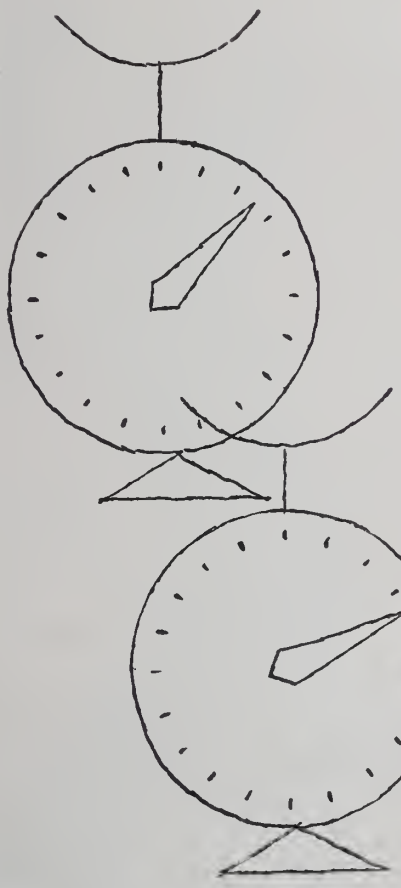
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1 Gardner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texas State J. M. 38:551, 1943
3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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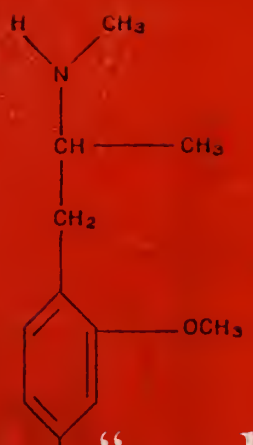
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1. Newcy, J. A., and Goetzl, F. R.: Permanente Med. Bull. 7:67 (July) 1949.



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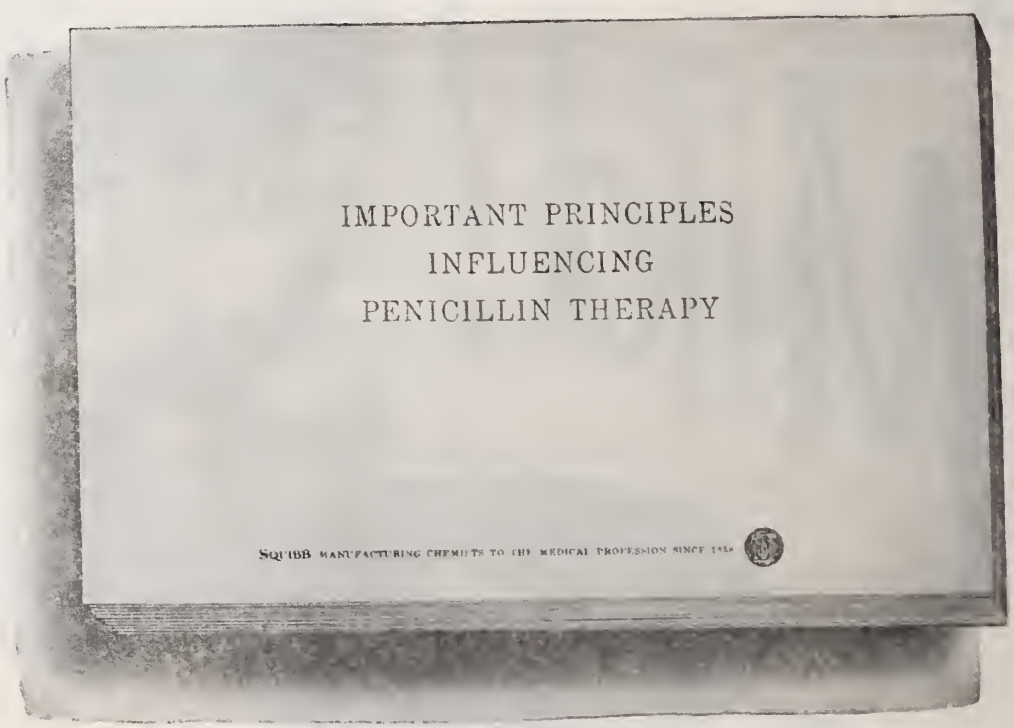
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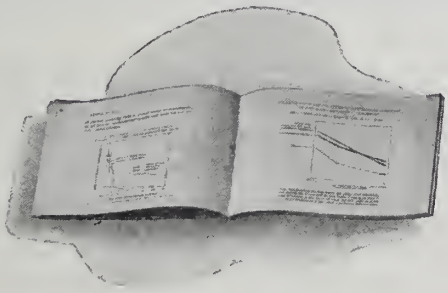
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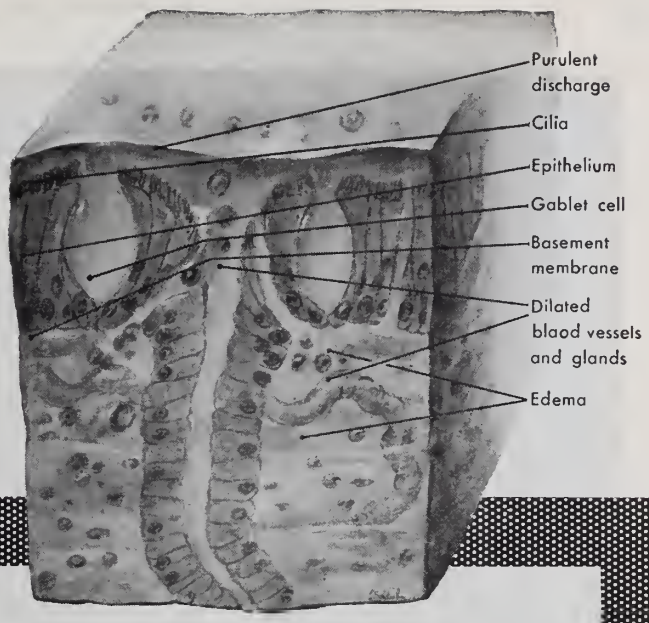
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Council on Pharmacy & Chemistry: New and Nonofficial Remedies. 1950, p. 218.



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1. Rehfuss, M. E., Albrecht, F. K., and Price, A. H.: A Course in Practical Therapeutics. Baltimore, Williams & Wilkins Co., 1948, p. 111.
2. Kelley, S. F.: In Cornell Conferences on Therapy. New York, Macmillan Co., 1947, Vol. 2, p. 156.
3. Gold, H.: In Cornell Conferences on Therapy. New York, Macmillan Co., 1947, Vol. 2, p. 151.

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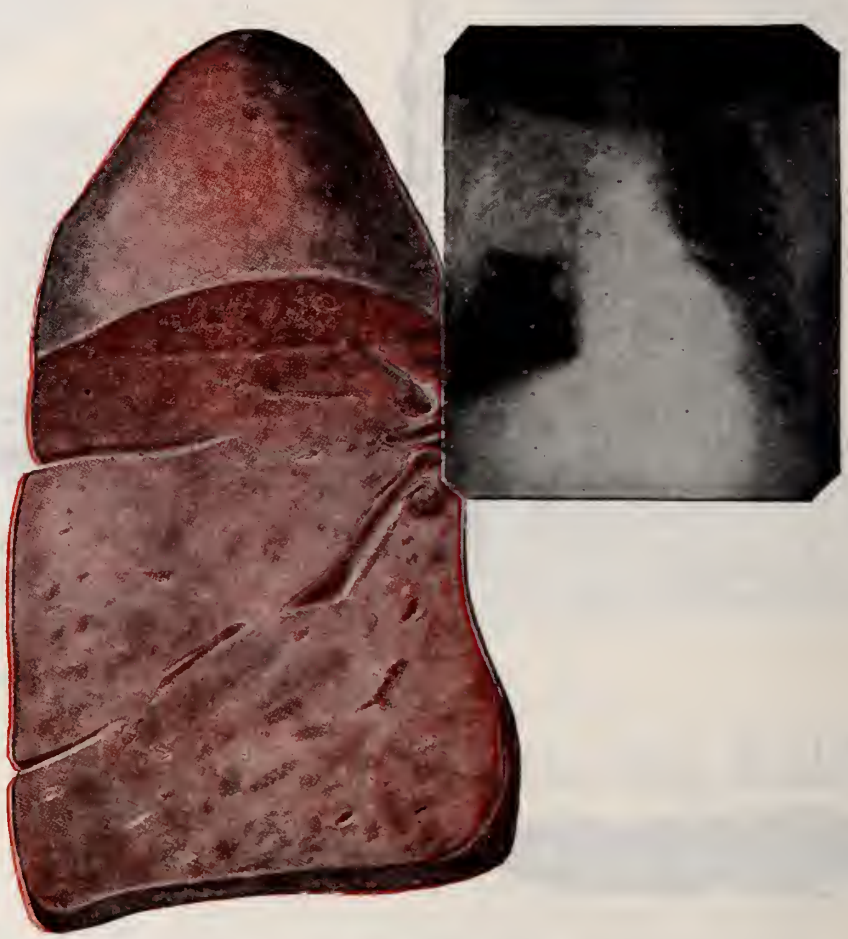
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Potterfield, T. C., and Starkweather, G. A.: J. Philadelphia General Hosp. 2:6 (Jan.) 1951

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Pulmonary infections associated with pancreatic insufficiency
Scarlet fever • Urinary tract infections
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Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

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Mixed bacterial pneumonias
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Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

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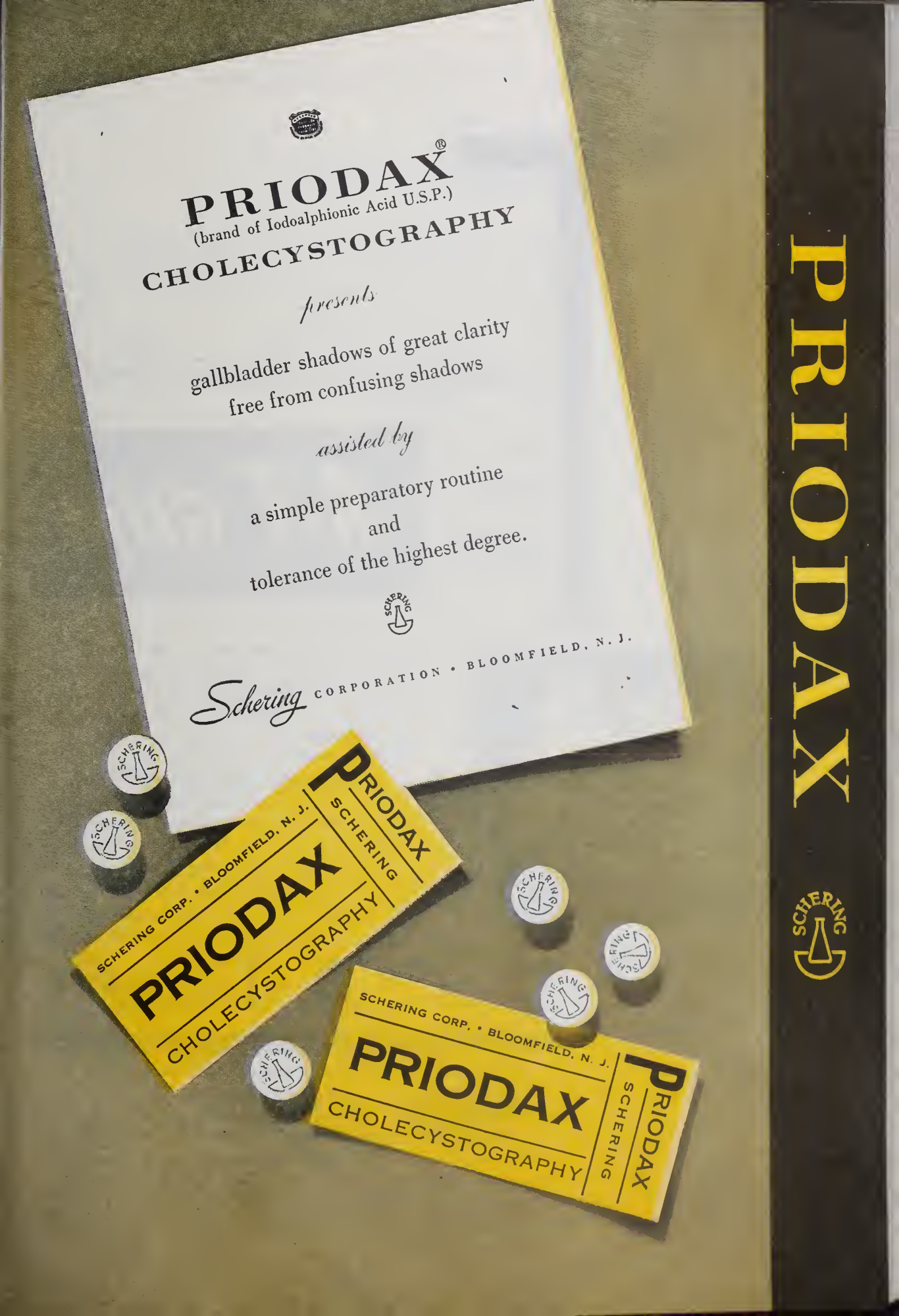
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1 Crowe, S. J., etc. al., Penicillin & Tyrothricin in Otolaryngology Based on a Bacterialogical and Clinical Study of 118 Patients, Ann. Otol., Rhinol. & Laryngol. 52:541, 1943.

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PRESIDENT'S MESSAGE

The recent Clinical Conference of the American Medical Association in Los Angeles in December was one of the best ever held.

Two outstanding facts concerning the American Medical Association were vividly demonstrated at this meeting. First, the American Medical Association, through its members from all state and county societies, has become an important political power. This fact was attested by the presence of two outstanding political figures—Senator Taft from the Republican Party, and Senator Byrd from the Democratic Party—speaking, directly to the House of Delegates and by radio to the entire country, in united opposition to any compulsory health insurance program. This in itself was dramatic, but both speakers gave evidence of further unity by strongly condemning the obvious efforts of the present administration to convert our historic free American economy to a socialistic serfdom. The united efforts of all our physicians in the coming election to prevent the furtherance of this substitution of socialism for our traditional system of free enterprise could be a determining influence upon our political history.

The second fact demonstrated was that the American Medical Association has definitely committed itself to a courageous, definite, and progressive advance by establishing a schedule of yearly dues.

We have all been guilty of taking for granted the benefits we receive from the American Medical Association. When it voiced its need for financial assistance to sustain all the activities necessary successfully to carry on our fight against

socialized medicine and to promote an active program to maintain our system of private practice, many physicians complained. However, when we consider the many and invaluable services the American Medical Association has rendered to us as members through all the years, and when we contemplate the multiplicity and importance of the many activities which it regularly carries on, we must come to the conclusion that membership in the American Medical Association is something which every physician must maintain for his own good and the good of the profession. Let us, therefore, align ourselves wholeheartedly with our national organization and cheerfully pay the necessary dues, which make possible the splendid and vital work which is being done.

SIGURD W. JOHNSEN, M.D.

MEMO TO ARTICLE WRITERS

Once upon a time words like "corn flakes" and "aspirin" and "linotype" had to be spelled with capital initials. They were trade names, dreamed up by some company official, and duly registered, copyrighted, and actually "owned". In public writing you couldn't use the words without permission of the copyright owners. Today many drug names are registered as trade-marks. If the manufacturing companies let you use their "protected" trade-names freely, their exclusive ownership would be watered-down. If you could call every camera a "Kodak", then the Eastman Company would lose the advertising value of the word they coined and worked so hard to popularize. That's what happened to escalators and aspirin.

All this is of interest to doctors who write articles and to that even larger group of doctors who expect to write a paper some time soon. In your daily conversation you use many of these trade-names glibly without giving thought to the fact that some company has registered and/or copyrighted them. However, Parke Davis does own the word "Adrenalin" and Smith, Kline and French have proprietary title to the word "Benzedrine". Butesin is made by Abbott Laboratories and nobody else. (And don't forget it if you write an article and refer to Butesin[1]). It is all right to mention "Dicumarol" casually in a staff-room conversation. But if you use the word in a published paper, be sure to tell the world that it is the "registered trademark of the Wisconsin Alumni Research Foundation". If you don't you'll hear from Wisconsin. So will the editor. And so it is with hundreds of others. Allonal means Hoffmann-LaRoche and Amytal means Lilly and Pyribenzamine is Ciba (but Benadryl, remember, is Parke Davis) and Demerol is Winthrop and Kaopectate is Upjohn and Progynon is Schering.

Sometimes it's hard to tell whether a drug name is "protected" by a company or whether it's in the public domain. You're safe with morphine and nicotinic acid, thiamine and picrotoxin, ephedrine and glutamic acid, penicillin and paraldehyde. They are all in the public domain. Most of the U.S.P. and N.F. products are common nouns. But that doesn't apply to NNR drugs. Most of them are trade-named.

When you write an article, don't guess about the drug. Its safe to assume that nobody owns the name "alcohol"; and "distilled water" is still in the public domain. But you never can tell. Pyrex is a trade-name and so is Vaseline (Chese-

1. We forgot it in publishing the paper by James and Bleiberg in last October's JOURNAL—a paper on occupational dermatoses. We let slip a reference to Butesin without indicating that it was a "proper" name. We forgot. Abbott Laboratories didn't. We apologize.

brough Manufacturing Company). It is easy to get confused between procaine (small "p") and Novocaine (capital N-tradenamed by Winthrop). Many of the products are listed in the valuable little *Physicians' Desk Reference*.[2] If you can't find it there, ask your pharmacist whether the drug is a common name or a protected trade-name. If the name is a company's trade-mark or if the word has been registered or copyrighted, be sure to indicate that in your manuscript.

It can be indicated by using a capital initial. If the patient alternates between aspirin and Dial, he gets the aspirin with a small "a" but the Dial is capitalized because Ciba Pharmaceutical Products own that. Or you can write a little letter "R" with circle around it after or above the name. That is, if your typewriter has an inscribed "R" on its keyboard. Ours doesn't. Or you can footnote it to the name of the manufacturing company the way we do in this JOURNAL. Or you can write the name of the company in parentheses immediately after the name of the drug. Or you can confine your therapy to the use of caffeine, calcium and curare, though that might limit your writing if not your practice. Probably the best bet is to ask your pharmacist. He's a good man to talk to now and then anyway.

Don't let all this discourage you from writing papers. You can always make a study of the effect of whiskey on the sense of dejection. No one has tradenamed that yet.

TUBERCULOSIS IS STILL WITH US

Every day four New Jersey citizens die of tuberculosis. That's every *day*, not every week or every month. And that's just the New Jersey score. It is a disappointing figure, because we had become rather smug about a disease that was once the Great White Plague. We know that it has long since been dethroned as the number 1 killer of human beings. Perhaps we have been lulled by the astonishing fall in the tuberculosis death rate since the turn of the century. So just to keep us from becoming too complacent, let's look at the New Jersey tuberculosis record.

It kills some 1400 New Jerseyites every year. It kills them at a median age of 47—more than 20 years earlier than the median age of death from heart disease. Thus the average tuberculosis fatality occurs at the prime of life, the acme of earning capacity. Every year, we find 3500 *new* cases (ten new cases a day) to add to New Jersey's roster of tuberculosis victims. With the possible exception of schizophrenia, tuberculosis is the most costly disease in the country, when you include loss of the earning capacity of its sufferers. Just in terms of cost of care alone, the disease cost New Jersey 34 million dollars in 1951. If loss of earnings are to be included, the price-tag would have to be doubled or trebled.

Tuberculosis is a disease which is peculiarly capable of control by education. This is because it is a communicable disease, and prevention of spreading is so much a matter of public and individual education. That is why the lay organizations are especially effective in tuberculosis work. They represent the public and can operate machinery for arousing public interest and developing public education. We in New Jersey can take pride in the fact that the National Tuberculosis Association was born in our state. And when the New Jersey Tuberculosis League calls the roll of its county

2. You don't catch us on this one. The *Physicians' Desk Reference* is printed in Rutherford, New Jersey, and is copyrighted by Medical Economics, Inc.

affiliates, the score is 100 per cent. There is a tuberculosis association in all 21 of our counties.

Our state's facilities are not quite adequate—but we don't have the worst facilities in the country either. We have more than 3000 tuberculosis beds (enough for all the new cases a year with none left over for older cases) and 16 tuberculosis hospitals. Patients can be successfully treated in the climate of New Jersey and—though we're not as richly endowed as we'd like to be—we do have the manpower, drugs and equipment needed for a tuberculosis program.

Tuberculosis is a relapsing disease. Medicine traditionally stops its interest when the patient recovers. Fortunately that tradition is on its way out. Doctors are developing an increasing interest in getting the patient back to the work-bench as well as out of the sick-bed. Here is a disease which requires top-notch coordination to effect the ex-patient's placement in his community plus the prevention of a relapse. It is a man-sized job and calls for help from doctors and social workers, public health nurses and vocational counsellors, boards of education and rehabilitation commissions, psychologists and dietitians, labor and industry. In a way our tuberculosis program is a touchstone of community team-work.

Unlike cancer or schizophrenia or multiple sclerosis, this is a disease where we know the cause, we know the pathology, we know how to treat the patient, how to discourage relapses and how to prevent the spread of the disease. But we need some of the momentum that kept the program in high gear during the first three decades of the century. The former Captain of the Men of Death will regain his saddle if we let self-congratulation and complacency slow down our activities or blunt the once sharp edge of our interest in tuberculosis.

THE NEW TURNPIKE

The physicians of New Jersey join with other citizens of our state in congratulating the members of the New Jersey Turnpike Commission upon the completion of the turnpike this month. This multi-laned highway, free of all traffic lights and sharp curves, links northern New Jersey near the George Washington Bridge with Newark, Elizabeth, the Amboys, and Camden, and continues southwestward to join the new Delaware River Bridge at Deepwater. Its significance will be appreciated by the physician whether he speeds southward on a well-deserved vacation, or hurries home from a scientific meeting at one or the other end of the state. Medical men from the northern and southern sections of the state will also benefit by greater accessibility to each other, and it will aid in the swift transportation of patients to urban medical centers.

Any measure which facilitates transportation and eases the heavy flow of traffic deserves praise, and the commission is especially to be commended for having achieved this herculean task in the face of material shortages, rising construction costs, and other handicaps.

ORIGINAL ARTICLES

RECENT ADVANCES IN ORTHOPEDIC SURGERY

Henry Briggs, M.D., Daniel B. Eck, M.D., and
Harold T. Hansen, M.D., Summit, N. J.

Specialization has brought many changes upon the medical scene during the past twenty years. Probably no specialty has made more far-reaching changes than has orthopedic surgery.

CHEMOTHERAPY AND ANTIBIOTIC THERAPY

Probably the most important single medical advance, in so far as orthopedic surgery is concerned has been the development of, initially, the chemotherapeutic agents, prontosil and the sulfa drugs. Later, the antibiotics, penicillin and many other agents made their appearances. These drugs have improved the prognosis in most bone and joint surgical cases and have eradicated the hazard of long standing infection. Thus, major bone surgical procedures previously undertaken only as a last resort, are now performed daily in even the smaller hospitals. New avenues have been opened up, making procedures, which might have been considered fantastic, commonplace.

Osteomyelitis, both acute and chronic, attacked first by the sulfonamide drugs, has been brought into reasonably close check with penicillin. Some of the more recent drugs with a wide bacterial spectrum, such as terramycin, show even greater promise.

Tuberculosis of the bones and joints no longer causes the orthopedic surgeon to think in terms of the long standing, draining sinus but, rather, to look forward to the prospect of eventual arrest, possible cure.

Syphilis too, seems to be passing still further into oblivion with the present day antibiotic therapy. Luetic manifestations in the bones and joints are becoming less and less frequent.

REFINEMENTS IN METALS

A second important advance reflected in improved technics in bone and joint surgery has been the improvement in the metals employed in internal fixation. The more or less universal adoption of stainless steel and vitallium, with their qualities of being practically "inert" when introduced into the tissues of the body, has eliminated another of the stumbling blocks in orthopedic surgery. No longer do we see the degree of absorption of bone previously existing with screws and plates made of poorly refined iron ores and silver. Further, both stainless steel and vitallium have been fashioned into many other useful forms, such as prosthetic heads for the femur, intramedullary nails for shaft fractures of long bones, et cetera.

BONE BANKS

Another useful adjunct in the advance of orthopedic surgery has been the introduction of the bone bank. Earlier orthopedic surgeons attempted to overcome the hazard of a poor surgical risk or an unduly long technical procedure by the employment of ivory and beef bone. Today both autogenous and homogeneous bone can be preserved and utilized at the desired time, thus reducing operative time, surgical risk and mortality in even the most formidable cases.

BONE METABOLISM

Laboratory and chemical research into the problem of bone metabolism has led to a better understanding of the healing of fractures, as well as the degenerative changes developing in senile bone. As a result, the use of hormones in the treatment of slowly-healing fractures has reduced the incidence of delayed union and non-union of fractures. This knowledge also permits a better appreciation of the problem of senile osteoporosis and a more satisfactory approach to its treatment through the aid of hormones.

FRACTURES

We have already mentioned chemotherapy, antibiotic therapy, the refinement of metals, the bone bank and the newer knowledge of bone metabolism which have had far-reaching effects upon the general approach to the treatment of fractures. Aside from these important influences, the most radical departure from previous methods has been the dynamic treatment of fractures as compared to the more passive static measures of an earlier era.

In contrast to the old dictum of "rest, uninterrupted and prolonged", newer methods of treatment completely omit immobilization. One of the first radical departures from the old beliefs came with the introduction of the hanging cast. When it became evident that some fractures healed better without firm immobilization, a new path was opened in the treatment of fractures. Skeletal traction came into greater vogue and, with it, a more dynamic and rational approach to the fracture problem. Muscles were not put to bed to rest in plaster until the bone healed; instead they were encouraged to perform some of their normal functions during the period of healing. The result was a better adapted and more easily rehabilitated patient. The management of the supracondylar fracture of the humerus in children is a good example.

Improved metals and relinquishing the tenet of immobilization brought forth a more dynamic treatment of femoral neck fractures with the introduction of the Smith-Petersen nail. Older victims of this type of fracture were saved from the consequences of long plaster immobilization — pneumonia, intercurrent infections and decubitus ulcers. The intertrochanteric fracture of the femur quickly rose to occupy the vacated place of the femoral neck fracture. It is still a problem but is challenged by the angle plates introduced by Neufeld, Thornton, McLaughlin, Moe, Moore and Blount.

A recent trend toward the dynamic treatment of shaft fractures of long bones began with the resurrection of the intramedullary method of fixation by Kuntscher in 1940. The success of this method in the treatment of fractures of the femoral shaft led to its application in the treatment of fractures of the humerus, ulna, radius, tibia and the metacarpals.

A still later method (and one which may even supplant the use of the Smith-Petersen nail in the treatment of fractures of the femoral neck) employs plastic and metallic femoral head prostheses after excision of the fractured head, thus permitting still earlier ambulation.

RECONSTRUCTIVE SURGERY

In the field of reconstruction, new methods and technics have developed so rapidly that it is almost impossible to keep pace with them. Antibiotics have opened new fields for exploration. Newer metals and the development of the bone bank have aided tremendously in the fruition of the thoughts and ideas thus stimulated.

Spinal column surgery has benefitted by the introduction of the Wilson plate for lumbosacral fusion. The bone bank has decreased the operating time and the risk in such procedure. Intensive investigation into the problem of the ruptured disc since its first mention by Dandy and its further definition by Barr has brought forth a flood of words and a wealth of literature. The old term, "lumbago" has almost disappeared from the popular vernacular. Technics of diagnosis and excision of the disc have improved. The longstanding debate of whether to fuse or not to fuse following excision is still unsettled.

Bone graft surgery has made few, but very important, changes since the days of Albee, Hibbs and Campbell. Again antibiotics, the bone bank and newer metals play a distinctive part. Perhaps one of the most far-reaching advances was the introduction of the dual bone graft by Boyd. Thereafter, the problem of bone defects seemed less formidable and many variations of the original tibial pseudoarthrosis technic found their place during and after World War II.

Surgery of the hip has benefitted tremendously by the introduction of the newer metals. The Smith-Petersen nail brought about a rational dynamic treatment of the femoral neck fractures. Later modifications and innovations have gone far toward solving the prob-

lem of the intertrochanteric fracture. Arthroplasty of the hip, popularized by Campbell, was improved by the introduction of the vitallium cup by Smith-Petersen in 1939. Judet then introduced a plastic prosthetic femoral head which has since been modified in both vitallium and stainless steel with a multiplicity of designs and uses so that it promises to revise the entire field of arthroplasty.

OTHER ORTHOPEDIC ADVANCES

Clubfeet: The static treatment of this condition by plaster fixation alone, has given way to more dynamic methods. Plaster has not been entirely abandoned, but its use in combination with the splints of Dennis-Browne has greatly improved the treatment of this condition.

Arthritis: An enriched biochemical knowledge of the causes of the two great types of arthritis has brought about a better orthopedic treatment. Treatment of the rheumatoid type with hormones now makes it possible to undertake bone and joint surgery as an adjunct to medical treatment with reasonable prospect of success. Treatment of the osteoarthritic type with hormones simplifies the orthopedic management.

Poliomyelitis: The zeal of Franklin D. Roosevelt and the endeavors of Sister Kenny (whether we accept her premises or not) have brought about improvement in the methods of treatment of poliomyelitis. True, the Kenny procedure was only a revival of older methods; but her claims and the resultant publicity coupled with the Roosevelt drive brought an impetus into the research and treatment of poliomyelitis which has been effectively perpetuated. Treatment is now earlier, more universally efficient and effective. Surgery is employed with improved rationale and handicaps are less pronounced. There is also the prospect of possible prevention despite the rising tide of cases in the past decade with a satisfactory vaccine in the offing. There is promise of improved diagnosis with a complement fixation test nearly a reality. With the realization of these, treatment will be greatly advanced.

Spastic paralysis: This condition has received considerable public attention and support during the past decade. Phelps, who now devotes his time exclusively to this condition, has done more than any other physician in furthering advances in this field. Following his classification of the types, a better understanding of the phenomenon of spastic paralysis has resulted, with effective surgery limited to the true spastic.

Prostheses: The war of 1939-1945 brought many improvements in prostheses. Of note is the suction socket type of prosthesis for the lower extremity, which, strange to say, originated in this country about the time of the Civil War. It was discarded and then resurrected by the Army Medical Corps in Germany. Its chief advantage is that it dispenses with the need of body straps. Another development in prostheses not yet perfected is the "I.B.M. miracle hand".

REHABILITATION

Medicine through the years has been concerned chiefly with diagnosis and treatment. Great effort has been made to improve diagnostic methods. The notable increase in laboratory examinations bears witness to this. Treatment in all fields has made rapid strides with new and improved diagnosis and with newer drugs. One of the most neglected fields has been postoperative treatment and rehabilitation.

However, the war with its need for putting troops back into the line, brought with it advances in rehabilitation. Instead of confining patients to bed for "rest, uninterrupted and prolonged", steps were taken to ambulate and rehabilitate the patients. Now decision as to treatment of injury or deformity is made with an eye toward early rehabilitation, as well as satisfactory outcome. During convalescence, the patient is encouraged to activate and exercise the involved parts so that they will be ready to accept physical effort once the parts are healed. Elaborate measures are taken to teach and train the individual with permanent residual deformity to become physically and economically useful despite limitations and handicaps.

382 Springfield Avenue

GASTRIC ULCER WITH MULTIPLE GASTRO-INTESTINAL DIVERTICULA

A. I. FRIEDMAN, M.D., Hackensack, N. J.

Do diverticula of the gastro-intestinal tract cause symptoms? Most authors[1] agree that they are "potentially" productive of difficulty such as inflammation, ulceration, hemorrhage, perforation, abscess or fistula formation. This is only a "potential" however. In proportion to their frequency, diverticula rarely cause symptoms since in so many patients they are found coincidentally during routine radiologic examination. Once the primary focus of the illness (such as peptic ulcer or cholecystic disease for example) has been satisfactorily treated, the patient usually becomes asymptomatic despite the continued presence of the diverticula. The question of symptomatology is related to the location, the size of the diverticulum, the width of the neck and the presence of residual food or of aberrant tissue.

Two varieties of diverticula located at both ends of the gastro-intestinal tract are notorious for the symptoms they produce. At the *proximal* end, a pulsion diverticulum, often called Zenker's diverticulum, requires surgery because it is usually incompatible with good health and adequate nutrition. This diverticulum actually arises in the hypopharynx and results from a weakness in the postpharyngeal muscular wall. As the sac enlarges it enters the mediastinum and vomiting and dysphagia result.

At the *distal* end, in the rectosigmoid, diverticula are especially likely to cause complications and the frequent sequel of diverticulitis leads to significant complaints. Straining at stool is an important factor in the growth and development of these diverticula. Here, too, surgery may be indicated, most often for the relief of obstruction or perforation, but occasionally for diagnosis. Large diverticula often produce symptoms by simple traction on the contiguous bowel. We have reported[2] the case of a physician with a huge Meckel's diverticulum the size of a grapefruit. This was seen on x-ray examination. The traction of the heavy sac produced intermittent attacks of intestinal obstruction. If the neck of the diverticulum is wide enough to permit prompt evacuation of the contents, inflammatory reaction is less likely. When the neck is narrow and food residue remains lodged within the diverticulum the fluid contents become absorbed and a hard, dry fecalith results. Now, superficial trauma of the mucosa produces an inflammatory reaction, later perhaps, ulceration, and finally, hemorrhage, perforation or abscess. Where aberrant tissue, gastric mucosa or pancreatic rests, is present within the pouch, ulceration and hemorrhage are more likely than in the simple mucosa-lined diverticulum of the gastro-intestinal tract.

An accurate visualization of diverticula without recourse to surgery can only be made by roentgen examination though some upper gastro-intestinal diverticula have been seen during esophagoscopy or gastroscopy. The incidence of diverticula discovered during radiologic examinations in a large hospital[3] was reported as:

(A) Gastric, 1 in 600 examinations.
(B) Duodenal, 1 in 150 examinations.
(C) Small bowel, 1 in 750 examinations.
(D) Meckel's, 1 in 1500 examinations.

CASE REPORT

Following is the history of a patient with diverticula of the esophagus, duodenum, jejunum and colon. In addition, during the roentgen examination a projection was seen on the lesser curvature of the stomach near the cardio-esophageal opening. Though the patient's symptomatology was acute, this was at first thought to be a gastric diverticulum in view of the associated diverticula. Following anti-ulcer therapy the lesion disappeared,

1. Such as Bockus, H. H., in *Gastro-Enterology*, Saunders, Philadelphia, 1946; and Fawcitt, R., in the British Journal of Radiology, 22:427 (August 1949); Edwards, H. C., in *Diverticula of the Intestine*, Wright, Bristol (England), 1939; and Johnstone, A. S., in the British Journal of Radiology, 22:415 (August 1949).
2. Marshak, R. H., and Friedman, A. I.: Gastro-Enterology, 15:754 (August 1950).
3. Fawcitt, R.: British Journal of Radiology, 22:427 (August 1949).

proving that it was a gastric ulcer. While all the diverticula are still radiologically prominent, the patient is today* completely free of symptoms.

A 71-year old man[4] was first seen on May 29, 1951, complaining of pain in the abdomen. His first siege of "stomach trouble" began in 1944, when he suffered upper abdominal pain intermittently for one year. He was hospitalized and a diagnosis of gastric ulcer was made. He became asymptomatic very quickly following therapy and was quite well until May 1951. At this time upper abdominal pain returned, lancinating in quality and radiating to the back and right shoulder. He complained that fried foods occasionally precipitated the attacks of pain. Food or milk produced relief. His symptoms were somewhat improved on lying down, though frequently, nocturnal pain did occur. There had been no history of vomiting, melena or hematemesis. He lost ten pounds during the 3 week period of his present illness.

He was a gaunt elderly man who appeared to be in considerable distress. His radial blood vessels were slightly sclerotic, but heart and lungs were negative. Blood pressure was 134/92. The left upper quadrant of the abdomen was tender, and at this area, there was considerable resistance to palpation. Rectal examination showed a formed stool. Sigmoidoscopic examination was negative. Hemoglobin was 11.1 Grams. Red cell count was 3.7 million. The leucocyte tally was 8700 with a normal differential count. Stool guaiac was negative. A fasting gastric analysis disclosed achlorhydria but following an alcohol test meal free hydrochloric acid up to 30 clinical units was found.

Barium meal examination revealed a traction-pulsion diverticulum of the mid-portion of the esophagus on its posterior aspect measuring 2.5 centimeters in diameter with a short neck about a centimeter wide. No other abnormality of the esophagus was found. High up on the lesser curvature on the posterior wall of the stomach, 2 centimeters below the esophageal orifice a projection measuring 1.0 by 0.5 centimeters in diameter was seen. Mucosal folds in this region could not be visualized despite compression studies. No neck was visualized. The contour of the lesion did not alter during the examination. The remainder of the stomach appeared normal. The duodenal bulb filled completely but behind it there was visualized a diverticulum 15 millimeters in diameter extending proximally from the second portion of the duodenum. Again, in the proximal jejunum just beyond the ligament of Treitz, there was seen another large diverticulum, this one measuring 2 by 4 centimeters in diameter. At the end of four hrs. the stomach was empty except for the patch of barium high up on the lesser curvature. The jejunal diverticulum still contained residual barium. At the end of 24 hrs. the sigmoid and the distal portion of the descending colon presented the rounded, irregular concentrations of barium typical of diverticulosis. A Graham-Cole study following the oral administration of a dye resulted in non-visualization of the gall bladder.



Figure 1—A smooth patch of barium is visualized high up on the lesser curvature aspect of the stomach on the posterior wall and immediately beneath the fundus. It measures 1.5 by 1.3 centimeters. No associated filling defects are seen. The adjacent rugal folds are normal. The huge, homogeneous mass of barium above the re-entrant angle of the stomach is the jejunal diverticulum. The duodenal diverticulum can be incompletely visualized behind the duodenal cap. These films were taken in May 1951.

The exact nature of the gastric lesion was difficult to determine. (See figure 1.) In view of the multiple diverticula present throughout the gastrointestinal tract, and the characteristic position of the lesion, a gastric diverticulum was suspected. However, since the roentgen pattern and the symptomatology were unusual for diverticulum, a gastric ulcer could not be excluded. The patient was placed on an anti-ulcer regime.

On June 15 he was seen again. This time he presented no complaints whatsoever. He reported that within three days, the epigastric pain had cleared. He had gained four pounds in weight. A repeat barium meal examination visualized the esophageal, duodenal and jejunal diverticula but the gastric lesion had completely disappeared. He was re-examined on September 17, 1951, and similar findings were noted. He was entirely asymptomatic and working hard daily. (See figure 2.)

Final diagnoses were benign gastric ulcer, diverticula of the mid-third of the esophagus, second portion of the duodenum and proximal portion of the jejunum, diverticulosis of the colon and non-visualization of the gall bladder, probably due to gall stones.

* November 30, 1951

4. He was referred to me by Dr. Harold J. Meyerson of Ramsey, N. J.



Figure 2—This film was taken in September 1951. The esophageal diverticulum is clearly visualized in the midesophagus. The jejunal diverticulum is above the lesser curvature of the stomach at the mid-corpus, and the duodenal diverticulum is the gas-filled projection immediately to the left. The gastric ulcer has completely disappeared.

COMMENT

Gastric diverticula are more common in females. While most gastric diverticula are asymptomatic, post-prandial epigastric pain with substernal radiation, dysphagia and cardiospasm may be present. Vomiting (with or without blood) may also be one of the symptoms. The cardia of the stomach is the most frequent location for gastric diverticula; here they are usually seen on the posterior wall near the lesser curvature immediately below the cardio-esophageal angle. They are best visualized in the oblique position, either right or left. Films taken in the erect as well as the prone position may facilitate identification. Occasionally the diverticula may be seen on a four-hour film following retention of barium in the pouch.

The differentiation of gastric ulcer from gastric diverticulum is extremely important both for the treatment and for prognosis. The differentiation is made by roentgen examination and confirmed by the clinical course. However, the roentgen characteristics are not always specific in the individual case. The diverticulum is usually oval, smooth in outline, often with a narrow base and mucosal markings are frequently observed. With retention of the barium meal in the sac, a fluid level may be seen. A stalk connecting the diverticulum with the corpus of the stomach may be visualized and the normal mucosal pattern in this area is usually distinct. When a stalk is present, the effect is that of a mushroom-shaped appearance. Sensitivity over the diverticulum is not elicited on palpation unless complications are present. The diverticulum frequently changes in shape during the examination. All this is in contrast to the findings in peptic ulcer of the stomach. The ulcer is unusual near the cardia, does not change in size, is usually tender to palpation and has a broad base with no neck. However, a perforated gastric ulcer may be separated from the gastric lumen by a fistulous tract. On the other hand, a peptic ulcer never possesses a definite mucosal pattern.

The roentgen films of this patient exhibited diverticula of the esophagus, duodenum, jejunum and colon. A projection also was seen on the lesser curvature of the stomach below the cardio-esophageal angle. Because gastric diverticula are common in this location this was thought to be another diverticulum. However, the usual roentgen characteristics of a diverticulum were not observed, and the possibility of a gastric ulcer could not be excluded. When the radiologic signs are equivocal, a test of clinical behavior may be diagnostic. In the last analysis *the most reliable test for differentiation between a gastric diverticulum and a gastric ulcer is the disappearance or diminution in size of the lesion following appropriate therapy*. This patient was put on an anti-ulcer therapy and several weeks later repeat roentgen examination revealed no evidence of the gastric lesion. This was obviously, therefore, a gastric ulcer.

SUMMARY

1. A 71 year old patient with multiple diverticula of the gastro-intestinal tract presented, in addition, a gastric lesion that was proven to be a benign peptic ulcer.

2. The differential diagnosis between gastric diverticulum and gastric ulcer is briefly discussed.

405 State Street

THE CASE OF THE FROZEN WOMAN

The first official report of the recovery of a person whose body temperature had dropped lower than ever before recorded in medical history was made by Dr. Harold Laufman,* of Chicago, in a recent release.

The victim, a 23-year-old woman, was found lying in an alley in a frozen coma by policemen, who assumed her to be dead, and brought her to the hospital. There, she was found to be breathing faintly. Her head could not be moved, her eyes were half-closed, her skin was cold and rubbery in consistency, her limbs were hard and could not be manipulated, and areas of frostbite were obvious. Two hours after admission, her temperature was 64.4 degrees F., and is believed to have been 60.8 degrees when she was discovered. The critical level in humans is considered to be between 68 and 74 degrees. No blood pressure reading could be obtained. Cortisone and a heart stimulant were administered.

Three and one-half hours later, when the patient showed difficulty in breathing despite an oxygen mask, an emergency tracheotomy was performed. Her arms and legs were dressed in pressure bandages, with the remainder of the body exposed to the open air of the room, which was kept at 68 degrees.

The victim's temperature rose steadily one degree an hour. Nine hours after being brought to the hospital, she opened her eyes and appeared to be able to see. Several hours later she was able to make herself understood.

Antibiotics were given to prevent infection. Other treatment included glucose in saline solution, whole blood and plasma, and anticoagulants. Amputations of the legs and of the fingers of the hands were deemed necessary and were performed one month after admittance to the hospital.

Physical therapy was begun three and one-half months after admission with excellent results. Two and one-half months later, she was sent to a convalescent home where she will be fitted with artificial limbs.

The woman had been drinking steadily for nine hours prior to the time she slipped on ice and lost consciousness. She had been exposed to temperatures ranging from one to seven degrees below zero, with a relative humidity of 58 to 70 per cent, for 11 hours; she was dressed very lightly.

The rapid lowering of this patient's temperature in relatively dry cold surroundings contributed to her survival, Dr. Laufman believed. The alcohol served as an initial soporific comparable to the administration of barbiturates or light anesthesia to experimental animals to offset the intense psychomotor disturbances and panic of the first stages of abrupt chilling. Furthermore, alcohol produces peripheral vascular dilatation at the expense of deep body temperature. Under these conditions a greater volume of blood was exposed to the cooling effect of the surroundings and hastened the drop in body temperature.

Study of this patient has shown that many conclusions reached in previous studies of frostbite and milder degrees of cold exposure do not apply to the severer types. More intensive animal experimentation of the more extreme types is needed.

* In the Journal of the American Medical Association, November 24, 1951.

CLINICAL EXPERIENCE WITH A NEW PROCESSED COAL TAR

S. J. FANBURG, M.D., Newark, N. J.

Crude coal tar has long been a favored remedy in the treatment of many skin diseases. It has, however, numerous drawbacks. It is messy, inconstant in action and composition, and sometimes productive of folliculitis. Numerous substitutes, modifications, and improvements have been devised, aiming toward the reduction or complete removal of its unsatisfactory features.

Coal tar has, on the whole, proved more satisfactory clinically than wood tar. The asphaltous sludge and the irritancy of its low molecular constituents are the most objectionable features of crude coal tar. One of the several approaches to overcoming this has been the production and use of distillate fractions of coal tar.

Distillates, while solving the problem of freeing the tar of the asphaltous muck, have yielded fractions that have failed to give completely satisfactory clinical results; at least, that has been my experience when comparing the clinical impressions from them and from the unprocessed crude coal tar.

I have had occasion to use and study the clinical effects of a new formula[1] containing irradiated processed coal tar.

The processed coal tar in this product is unique in several respects. Crude coal tar is processed with the aid of a vegetable oil so as to remove the low molecular irritants and the inert asphaltous sludge in a single step. Whatever is rightly a distillate in this processing is discarded. What is used is the residual liquid after distillation and precipitation of the inert sludge. This tar-vegetable oil fraction is submitted to ultra-violet light radiation to induce in the oil organic peroxides[2] (ozonides). These ozonides[2] have been reported to be effective keratolytics as well as antiseptics.

1. Dencotar Ointment Sulphurated—The Denver Chemical Manufacturing Company.
2. Sharit, H.: N. Y. State Journal of Medicine, 46:1247 (October 1946).
3. Lutheran Memorial Hospital, Newark, N. J.
4. Dencotar Shampoo is made by The Denver Chemical Manufacturing Company.

The ointment base of the product here reported upon is of the "cosmetic" type allowing for maximum absorption. The character of the base in influencing absorption rates of ingredients is significant for tar since it plays an important part in the determination of adequate concentrations; the easier the absorption therefrom, the less ingredient concentration is required. Preliminary clinical testing disclosed the relatively small concentration of the tar ingredient sufficient for maximum therapeutic results. In addition to the specially processed tar, Dencotar[1] ointment contains precipitated sulfur, menthol, and starch. The ointment is tan in color with a faint tar odor. Rubbed into the skin or scalp it completely disappears without leaving a greasy film. It is easily removed with soap and water or even with water alone. It does not stain the skin or clothing.

To appraise the value of this new preparation clinically, it was used in 56 cases of seborrheic dermatitis, 14 cases of nummular eczema, 16 of psoriasis, and 19 of atopic dermatitis. There were also a few cases of pityriasis rosea, parapsoriasis, pruritus ani, and lichen planus. The total number of cases treated and individually observed in the office and clinic[3] by the author was 112.

There were 56 cases of seborrheic dermatitis of the face and scalp. After using the Dencotar[1] ointment daily for an average of two weeks, in conjunction with a tar shampoo made with the same processed tar ingredient,[4] used once a week, 40 patients showed considerable improvement. Redness, scaling, and itching were entirely cleared. These patients were asked, however, to continue the ointment and shampoo once a week to prevent recurrence. In 15 cases there was diminution of the redness, scaling, and itching, but not complete clearing. In one case there was no improvement.

Nummular eczema is probably of endogenous origin and usually appears on the hands,

Cases	Disorder	Much Impr.	Mod. Impr.	Not Impr.	Worse	Percentage Much Impr.	Overall Percentage Improved
19	Atopic dermatitis	14	4	0	1*	74%	95%
2	Lichen planus	0	2	0	0	0	100%
14	Nummular eczema	9	3	1	1*	64%	86%
1	Parapsoriasis	1	0	0	0	100%	100%
1	Pityriasis rosea	1	0	0	0	100%	100%
16	Psoriasis	12	4	0	0	75%	100%
3	Pruritus ani	1	0	2	0	33%	33%
56	Seborrheic dermatitis	40	15	1	0	86%	98%
112	Total	78	28	4	2*	69%	95%

* These patients had been previously sensitized to tar.

arms, and legs. It is resistant to all forms of therapy and has a tendency to recur. There were 14 cases of nummular eczema in this group. Nine were considered improved, three were moderately improved, and one was aggravated. Investigation revealed that this patient was sensitive to tar preparations, having been irritated previously by other forms of tar.

Sixteen cases of psoriasis were treated with Dencotar[1] ointment, rubbed into the affected areas twice a day. Twelve were much improved and four moderately improved. The ointment had a beneficial effect insofar as reduction of scale, itching, and erythema was concerned. In some cases numerous areas of psoriasis cleared completely. Others changed slightly. On the whole, the effect was good. In a disease as capricious as psoriasis, these results were impressive.

Of the nineteen cases of atopic dermatitis, fourteen were much improved, four moderately, and one was aggravated. In this last case, the patient had previously been unable to tolerate tar in other forms.

One case of parapsoriasis treated was improved; of the three cases of pruritus ani, one was helped, two were not; of the two cases of lichen planus, both reported relief of itching. The one case of pityriasis rosea which was treated with this preparation was relieved of itching and scaling.

SUMMARY

1. A new type processed crude coal tar in the form of an ointment[1] and shampoo[4] is discussed.

2. The coal tar used in these preparations has had the low molecular irritants and inert sludge removed by processing crude coal tar in a vegetable oil and irradiating to produce ozonides (organic peroxides).

3. An ointment containing the processed coal tar[1] was found helpful in a wide variety of skin disorders. In seborrheic dermatitis of the scalp, a shampoo[4] containing the new type tar was used in conjunction with the ointment with very satisfactory results.

4. The new processed crude coal tar ointment and shampoo are safe, clean, and more efficacious than ordinary crude coal tar preparations.

31 Lincoln Park

LUCAINE HYDROCHLORIDE FOR OBSTETRICAL SPINAL ANALGESIA †

PRELIMINARY REPORT

CARMINE DE VIVO, M.D., Newark, N. J.

Lucaine Hydrochloride,* a local anesthetic of the piperidine group, has been used with considerable satisfaction at East Orange General Hospital as a spinal anesthetic in obstetrics.

First reports concerning the chemistry and pharmacology of this anesthetic, which is chemically Beta-(2-piperidyl)ethyl ortho-aminobenzoate hydrochloride, were published by Walter and Fosbinder[1] and Hunt and Fosbinder.[2] Many local anesthetics are esters of benzoic and para-aminobenzoic acid; but Lucaine* is an ester of *ortho*-aminobenzoic acid. It occurs as a white crystalline powder, readily soluble in cerebro-spinal fluid and in glucose solutions to form anesthetic concentrations of from 0.5 to 2 per cent. One per cent solution in spinal fluid (specific gravity 1.008) has a resulting specific gravity 1.012; the same solution in equal parts of 5 per cent glucose and spinal fluid has a specific gravity of 1.024. Lucaine Hydrochloride* will withstand autoclaving at the usual temperatures and pressures.

In comparison with drugs of merited application for spinal anesthesia, Lucaine Hydrochloride* has a prolonged duration of sensory anesthesia and satisfactory safety margin. It does not irritate tissue.

Early clinical reports by Finer and Rovenstine[3] indicated that Lucaine Hydrochloride* spinal anesthesia, in the recommended dosage range, was unique since when sensory analgesia was profound, it was not accompanied by motor involvement. This selective action of Lucaine Hydrochloride* on sensory and autonomic pathways with little or no motor involvement encouraged its use in obstetrics, genito-urinary operative procedures and in operations on the lower extremities.

Roman and Adriani[4] reported on the use of Lucaine Hydrochloride* as a spinal anesthetic for urologic surgery and showed that the drug yields sensory anesthesia of moderate duration with no motor paralysis. A low incidence of hypotension with Lucaine* was also reported.

Cull and Schotz[5] found Lucaine* an effective spinal anesthetic for operative procedures outside the peritoneal cavity, as for example in transurethral and suprapubic operations on bladder and prostate, operations on the anus, perineum and lower extremities, pilonidal cystectomies, varicose veins and skin grafts. Good analgesia with relaxation and retention of voluntary control over the musculature in the analgesic zone indicated a predominant effect on sensory nerve elements. These investigators also commented on the low incidence of hypotension with Lucaine* spinal anesthesia.

Barnes and Hapke[6] used Lucaine Hydrochloride* in glucose for obstetric saddle block anesthesia in 362 patients. The outstanding characteristic noted was, that to a great extent, motor power was retained below the level of anesthesia. For this reason, the patients' ability to employ the voluntary forces of expulsion was greater than under other forms of spinal anesthesia. Thus the cooperation of the patient in her delivery was largely retained. Moreover, these authors reported a reduction in the frequency of forceps rotation or midforceps when Lucaine Hydrochloride* was employed, as compared to a control series where hyperbaric Nupercaine‡ was used.

The term "saddle block" designates a form of low spinal anesthesia involving the lowermost sacral spinal segments,[7] confining the anesthesia to the "saddle area" innervated by the sacral nerves.[8] In practice, however, obstetric spinal anesthesia, whether for vaginal or abdominal delivery, rises to the tenth thoracic areas, the level of the umbilicus, if analgesia of uterine "pains" or surgery is to be obtained.[9] Thus, the term "obstetric saddle block" may be modified to mean simply a low spinal analgesia.[10] The term "saddle block" is well

† From the Department of Anesthesiology, East Orange (N.J.) General Hospital.

* Lucaine Hydrochloride, brand of pipethocaine hydrochloride, was supplied by Maltbie Laboratories, Inc., 240 High Street, Newark 1, N. J.

1. Walter, L. A., and Fosbinder, R. J.: Journ. Am. Chem. Soc., 61:1713 (1939).
2. Hunt, W. H., and Fosbinder, R. J.: Anesthesiology, 1:305 (November 1940).
3. Finer, G. H., and Rovenstine, E. A.: Anesthesiology, 8:619 (November 1947).
4. Roman, D. A., and Adriani, J.: Urologic and Cutaneous Review, 52:653 (November 1948).
5. Cull, W. H., and Schotz, Seymour: Anesthesiology, 11:353 (May 1950).
6. Barnes, A. C., and Hapke, F. B.: West. J. Surg., Obstet. and Gynecology, 58:76 (February 1950).
7. Adriani, J., and Roman-Vega, D.: Surgery, 71:12 (January 1946); Parmley, R. T., and Adriani, J.: Am. Journal of Obstet. and Gynec., 52:636 (October 1946).
8. Maxson, L. H.: *Spinal Anesthesia*, J. B. Lippincott Co., New York, p. 364 (1938).
9. Greene, B. A.: New York State J. Med., 49:1527 (July 1949).
10. Cullen, S. C.: *Anesthesia in General Practice*, Year Book Publishers, Inc., Chicago, 3rd ed., p. 161 (1951).

‡ Nupercaine, also known as dibucaine is a Ciba Pharmaceutical Product, derived from butyl oxy cinchoninic acid.

chosen in that it does not bear the implication to the patient that the term "spinal" does.

Properly performed obstetrical spinal anesthesia should not stop or hinder the progress of labor. Correctly administered (and confined to its proper level) saddle block spinal has an inconstant and minimal effect on uterine contractions since the motor nerve elements to the active uterine segment generally leave the spinal cord in sympathetic nerves at high thoracic levels. On the other hand, the preservation of the *voluntary* expulsive force in obstetrics may well be useful. It has been demonstrated by rectal balloon-manometer studies in obstetric patients that the voluntary expulsive effort is retained in greater degree with Lucaine Hydrochloride* anesthesia than with other spinal anesthetic agents.[6] Thus the patient retains a greater ability to cooperate in her delivery without sacrifice in the degree of analgesia obtained.

The present study is a preliminary investigation and appears to bear out the conclusions of previously published works.

DOSAGE AND TECHNIC

Saddle blocks were administered to primiparas when the cervix was 6 to 8 millimeters dilated and to multiparas when 4 to 6 millimeters dilated. Spinal puncture was done with the patient in the sitting position through the second or third lumbar interspace. The patient remained in the upright sitting position for 30 seconds; then she was placed in the recumbent position, with a pillow supporting the head. The table was tilted to reverse Trendelenburg position at approximately 5 degrees. Onset of sensory anesthesia was as rapid as with procaine and was obtained in 5 minutes. During this time, the table was adjusted to maintain the anesthetic level at about the tenth thoracic segment. "Fixation" of the anesthetic was complete in 15 to 20 minutes.

The dosage of Lucaine* was 30 milligrams. This was dissolved in either 3 cubic centimeters of 10 per cent glucose or 2 cubic centimeters of 10 per cent glucose plus one cubic centimeter of ephedrine solution (50 milligrams) or 2 cubic centimeters of 10 per cent glucose plus 1 cubic centimeter of 1-to-1000 epinephrine. At first, intramuscular ephedrine was not given prophylactically to combat hypotension. However, some patients did experience a drop in pressure with accompanying nausea. Later, all patients received 25 milligrams of ephedrine intramuscularly routinely prior to spinal puncture.

RESULTS

A summary of observations on 17 patients is shown in the table.

Within 5 minutes after administration, there was sensory analgesia to the tenth thoracic level. Perineal relaxation was observed at this time and no paresis of the extremities was encountered. Patients would frequently remark that their legs "felt a little different" but they never lost the ability to move them freely. There appeared to be a difference of at least two and possibly three dermatomes in the sensory and motor levels of anesthesia.

Labor contractions continued without change in strength or frequency. Multiparas were usually allowed to deliver spontaneously. Primiparas were, as a rule, delivered with outlet forceps. Analgesia was adequate enough to employ midforceps. The use of forceps in this series was not related to a definite obstetric need but to the individual choice of the obstetrician.

All patients experienced satisfactory analgesia and all were comfortable and cooperative and would "bear down" when told they were having a contraction. Complemental anesthesia was not necessary except in one instance when delivery was completed 12 hours after saddle block.

It was difficult to ascertain the absolute duration of complete analgesia since most of the patients delivered and underwent perineal repair while anesthesia was still effective. It is safe to say that *at least* two hours of analgesia was produced with 30 milligrams of Lucaine.* The duration of anesthesia was prolonged when ephedrine and/or epinephrine was added to the glucose solvent. Epinephrine was more effective than ephedrine in prolonging anesthesia, the duration of analgesia extending from 2½ to 5 hours. This confirms

the potentiating effects of epinephrine on Lucaine* anesthesia as reported by Roman and Adriani.[4]

A low incidence of hypotension was noted. This is accounted for, in part, from the routine use of ephedrine intramuscularly. Some postpartum nausea and headache were reported but in no instance were these severe.

Although this is admittedly a small series, we conclude that Lucaine Hydrochloride* is a safe and effective spinal anesthestic for obstetrical analgesia and it possesses ability to produce sensory analgesia without significant loss of motor power.

OBSTETRICAL ANESTHESIA (SPINAL) WITH 30 MILLIGRAMS OF LUCAINE*

Case	10% Glucose	Ephedrine 50 mgm	Epinephrine 1/1000	Parity	Fall in b.p.	Duration of Anesthesia 14	Forceps	Nausea	Vomiting	Headache
1.	3 c.c.	0	0	P	15 min[11]	2 hrs.	Ot	none	none	none
2.	3 c.c.	0	0	P	10 min[11]	2½ hrs.	Ot	slight	none	none
3.	3 c.c.	0	0	M	none[11]	½ hour	none	slight	none	none
4.	3 c.c.	0	0	M	20 min[11]	2 hrs.	Ot	slight	slight	none
5.	3 c.c.	0	0	M	none[11]	1 hour	none	none	none	none
6.	3 c.c.	0	0	P	15 min[12]	1 hour	none	slight	none	slight
7.	2 c.c.	1 c.c.	0	M	5 min[11]	2½ hrs.	Ot	none	none	none
8.	2 c.c.	1 c.c.	0	P	5 min[11]	2½ hrs.	none	none	none	slight
9.	2 c.c.	1 c.c.	0	P	none[11]	1 hour	Ot	slight	none	slight
10.	2 c.c.	1 c.c.	0	P	none[12]	2½ hrs.	none	none	none	none
11.	2 c.c.	1 c.c.	0	P	none[12]	3 hrs.	Ot	none	none	none
12.	2 c.c.	1 c.c.	0	M	none[12]	3 hrs.	none	none	none	none
13.	2 c.c.	1 c.c.	0	M	none[12]	1½ hrs.	none	none	none	none
14.	2 c.c.	0	1 c.c.	P	none[11]	2½ hrs.	none	none	none	none
15.	2 c.c.	0	1 c.c.	P	none[12]	5 hrs.	Ot	slight	none	none
16.	2 c.c.	0	1 c.c.	P	none[12]	4½ hrs.	Ot	none	none	none
17.	2 c.c.	0	1 c.c.	P[13]	none[11]	4½ hrs.[13]	none	none	none	none

11. Parenteral ephedrine omitted.
12. Ephedrine, 25 milligrams, intramuscularly before anesthesia.
13. Block repeated. Inaccurate forecast of delivery time. Anesthesia duration 3 hours on second block.
14. See explanation in text.
P. Primipara.
M. Multipara.
Ot. Outlet forceps used.

188 South Sixth Street

HEART SYMPOSIUM: MARCH 19

The New Jersey Heart Association announces a symposium on heart disease to be held at the Academy of Medicine, 91 Lincoln Park, Newark, on Wednesday afternoon, March 19. The program:

2:00 p.m.—Sodium and potassium metabolism in patients suffering from heart disease. J. R. Elkinton, M.D., University of Pennsylvania.

2:30 p.m.—The heart during anesthesia. C. L. Burstein, M.D., Hospital for Special Surgery, New York.

3:00 p.m.—Ballistocardiography. Harry Mandlebaum, M.D., State University (N.Y.) Medical Center.

4:00 p.m.—Cardiac surgery. Dwight E. Harken, M.D., Peter Bent Brigham Hospital, Boston.

4:30 p.m.—Rheumatic fever. Leo M. Taran, M.D., Roslyn, Long Island.

5:00 p.m.—Circulatory responses to life situations. Stewart Wolf, M.D., Cornell University Medical College.

PANEL DISCUSSION ON HEADACHE

Headache will be the topic of a panel discussion scheduled for March 31, at 8:30 p. m. in the main lecture hall of the New York University College of Medicine at 477 First Avenue. For tickets (gratis) and further information, write to New York University, 100 Washington Square, New York 3, N. Y., Attention, Alumni Office (Medicine).

TUBERCULOSIS CONTROL PROBLEMS

Irving Willner,* M.D., Newark, N. J.

The control of tuberculosis by methods now being used is far from satisfactory. True, there has been the lowering of both morbidity and mortality rates by present methods. However, many problems keep these rates from being reduced to a minimum.

Susceptibility to infection by the tubercle bacillus is present at any period of life but has apparent affinity during childhood and during old age. Frequency of exposure especially in close contact and with a person over a prolonged period increases the danger of spreading the disease. The resistance of the individual is a factor in determining whether the disease is localized and arrested or whether it spreads not only through the lungs but other parts of the body. Most people are exposed at some time or other but only a small ratio of the population actually develops active pulmonary tuberculosis. Personal resistance forms one factor in prevention but most important are proper housing, good nutrition, modern sanitation and elimination of extreme poverty. Children may develop primary and reinfection types after a short period of exposure.

Fatal tuberculosis usually results from a massive primary infection against which there is little or no resistance. Some fatal cases are of the "reinfection" type with rapid spread throughout both lungs. The "adult type" among children is the result of constant contact with a patient who has active tuberculosis and a positive sputum. More tuberculosis results from direct contact within the family than from any other source. Most of these come from congested slum areas. Close medical supervision of children has resulted in improvement in both morbidity and mortality rates within recent years as the result of tuberculin testing in schools and clinics, subsequent x-raying with early diagnosis, and instituting treatment as soon as possible.

The tuberculosis program was concentrated on children and the younger age groups for many years but our records in the past five years now show that the problem concerns chiefly the older age groups. Older people are now a greater part of the population and due to medical progress, will continue to be so. Active disease among the elderly results from an exacerbation, the actual onset occurring many years prior. Our tuberculosis control is now intensified among the older age group. Many patients, long treated for "chronic bronchitis" or "asthma", have proved to have active tuberculosis. Many of these patients stubbornly refuse to believe that they have tuberculosis. In spite of all our efforts, they just will not change their mode of life. Yet it is a clinical fact, that tuberculosis is increasing among persons beyond middle age. Among the old, as a result of debilitating conditions and chronic diseases (especially diabetes) pulmonary tuberculosis is often activated or aggravated.

TABLE I

Tuberculosis Located Among Patients Over Age 55
(Newark, N. J.)

Year	*Patients*
1945	98
1946	112
1947	101
1948	114
1949	116
1950	111

(Increase in past six years: 11 per cent.)

Locating active and "suspicious" cases is a major problem. Tuberculosis spreads by contact. Finding the infected individual is essential. An ideal procedure would be to x-ray everyone over fifteen years of age within a short period and do tuberculin testing below this age. Attempts to follow this procedure have not been encouraging. In Newark, stationary x-ray units have been placed in various slum areas and mobile units have been moved from street to street to x-ray as many as possible. In the mobile and stationary units, x-rays are taken on 70 millimeter films while at the Newark Health Department, a photofluorographic unit, (4 by 5 inches) is used. Prior to all x-ray projects, an educational program was instituted by distributing thousands of pamphlets to all homes in the area. Newspaper articles, radio and television talks stressed

* Dr. Willner is the physician-in-charge Chest Disease Division, Newark (N.J.) Department of Health

the prevention of tuberculosis. Lectures were given and motion pictures shown to parent-teacher groups and other organizations. We made contact with all physicians and clergymen in the area, and the ministers were requested to mention the drives in their Sunday sermons. The doctors were asked to recommend chest x-ray to their patients and reports of all abnormal findings were later forwarded to them. Most physicians cooperated and requested patients to visit the area designated for the x-ray unit. Guidance and leadership in every antituberculosis campaign is a responsibility of the medical profession. Medical practitioners have a duty to the community to take an active part.

Results of the tuberculosis detection drive were far from satisfactory. Only a small proportion of individuals responded to the appeal. A few active and suspicious cases were located. Active cases were placed under treatment and suspicious ones followed for more detailed examination by clinical examination, sputum tests, 14-by-17 inch films, and other necessary procedures. Some cases of tuberculosis were reported by private physicians and others were located through the clinics of the Health Department where x-raying of the chest is routine regardless of the patient's presenting complaints. All children attending City Dispensary clinics are submitted to a tuberculin test. If a positive reaction occurs, the child himself, the members of his family and all other available contacts are x-rayed. A tuberculin testing program is also conducted in the public and parochial schools. The Child Hygiene Division of the Newark Health Department is cooperating in the program so that all children are tuberculin tested before admission to schools. Another compulsory program is the x-raying of food handlers and domestics employed in Newark. A negative plate is a requisite for employment. Many in slum sections are on relief and, under an ordinance, attend city clinics where x-rays of the chest are routine. This procedure should be followed in out-patient clinics of all hospitals. We have long recommended a general screening of all clinic cases as well as x-raying all bed patients in the hospital.

The responsibility for control of tuberculosis depends largely upon public health officials, although agencies can render valuable cooperative service. Adequate facilities for control must include clinical service, field nursing and hospital care. Case finding especially in slums requires intensive investigation, not only in clinics but through home visits by the public health nurse. Interviews with patients whose tuberculosis is known to be active, and with their contacts lead to the findings of many new cases. The earlier the infectious person is located, the more rapid the treatment and the better opportunity for checking spread of the disease. In the Health Department clinics, work is carried on by physicians and nurses. In the field we have a supervisor, an assistant supervisor and fifteen public health nurses. Clinics are conducted daily during the morning and afternoon and are staffed by doctors specializing in lung diseases. Prior to examination, a detailed history is taken.

Field nurses interview all known infectious patients and see that they are under treatment by private practitioners, or in one of the city clinics. Sanatorium care is recommended when necessary and all contacts must be examined and x-rayed. Where a private physician is in charge, the nurses cooperate and assist in the recommended routine. The nurse must enjoy the confidence of the family to perform her duties properly. She is best able to do this by allowing the family to explain their problems rather than by imposing prophylactic measures at once. Observation will lead her to know not only the health requirements but the social and economic factors. A field nurse needs an intimate knowledge of the social, welfare, health and other agencies in the community which may be called on to assist. She follows-up all children with positive tuberculin reactions and sees that they and all their contacts are x-rayed. In performing her activities it is essential that she:

1. Possess alertness to problems of disease prevention.
2. Become well acquainted with the district she covers.
3. Recognize opportunity for teaching in simple language both patient and family.

4. Have close contact with all known active cases and visit them often.
5. Routinely communicate with and check (for x-rays and examinations) all suspicious cases.
6. Cooperate with the family physician if there is one.
7. Consider the racial, religious, cultural and social beliefs of each family.

Better hospitals, care of the known cases with isolation and modern therapy will prolong life and help arrest the disease. To rid the community of tuberculosis, requires better housing, proper sanitation, education, good economic conditions, a well-balanced nourishing diet, and intensive local health service. Perhaps among the new antibiotics, one will be discovered to destroy the tubercle bacillus.

The high proportion of cases that are never identified until at, or just before, the time of death is astounding. These people wander among the population during their infectious state, spreading tuberculosis without ever being recognized. In 1950 alone, 76 cases were found just prior to or immediately after death. This constitutes 37 per cent of all who had died of tuberculosis that year! In previous years, 16 to 25 per cent of the cases were unknown until after death.

Uncooperative cases are common. The floater, the derelict and the drunkard constitute major obstacles to an effective control program. Difficulty in isolating the open, active case and keeping him from infecting contacts has long been a problem. A serious condition (prevalent in Newark and in many other parts of the country) is that many patients cannot be hospitalized or placed in a sanatorium due to lack of beds. Waiting lists are often long. Months may elapse before admission. In Newark, only one local institution (the City Hospital) will accept them and their wards are usually over-crowded. As a result, patients with open tuberculosis are permitted to wander about, or live in homes where children are present. Tuberculosis is propagated by direct contact with an infected person. The longer the association, the greater chance for spread. The active case is definitely infectious and is a public health hazard. Even when we get the bed, many patients refuse to go to a sanatorium, citing all sorts of "reasons". Some feel that they are not sick enough to go away, or are under the care of a private physician who has advised them to remain home. Others do not believe the diagnosis, and no amount of persuasion can convince them—even demonstration of positive sputa and x-ray findings. Some feel that they can get well at home. Others have an irrational dread of institutions. A few refuse to go on religious grounds believing that they cannot have any active infectious disease. Others assert that they will not obtain proper medication when hospitalized. This is a common complaint among chronic alcoholics who fear they will be unable to get liquor while confined. Another problem is to keep the active patient in the institution once he arrives. Some become so boisterous and unruly that they interfere with the conduct of the hospital and have to be discharged. In most hospitals, at any time after admission, the patient can sign a release and leave at once. These problems are common among alcoholics. Recently one such patient was unruly, then broke into a drug cabinet, and a few days later started a fire.

It is sometimes suggested that these stubbornly uncooperative patients are, in effect, mentally ill, since they seem bent on harming themselves and others for no sane reason. On this theory, we tried sending some of the more "incorrigible" patients to psychiatric hospitals. This plan did not work either, since in most of these cases, the psychiatrists were unable to find any certifiable psychosis.

Another possibility is quarantine at home. This entails unending supervision, and in practice is almost impossible to enforce.

The entire question of treating the menacing, disease-spreading patient, who will not cooperate, is a troublesome one. We have discussed this with the State Department of Health and a plan is now under consideration for creating a tuberculosis ward in one of the penal institutions. This will permit compulsory hospitalization in a maximum-security installation until the patient's disease is arrested. A sanatorium is not a jail and a rigorous, "compulsory" plan is naturally distasteful to all of us. However, it is apparent that we must have a state-supported building for the enforced housing and treatment of those highly

infectious patients who simply will not cooperate in any less coercive plan. Compulsory isolation is unwelcome, but it is essential when a patient who is a positive menace to others refuses a noncoercive treatment program.

In Newark (N.J.) tuberculosis morbidity and mortality have been declining for many decades. In 1950, the rate per hundred thousand was 47.2, one of the lowest on record. To appreciate what this means, remember that in 1915 the corresponding rate was 198. But our task is far from ended. There is still much to do.

94 William Street

RECENT ADVANCES IN THE TREATMENT OF EXTENSIVE BURNS

Lester W. Eisenstodt, M.D., Newark, N. J.

In the past decade the mortality of severely burned patients has diminished considerably. Improved skin graft technics, early operations and better medical therapy have contributed to our good results. Prior to 1940, most adults with half of their body area burned were considered fatalities. Today, adults with 70 per cent of their body area burned usually survive.

Extensive burns are always a threat to life. Anemia and hypoproteinemia make their appearance early due to the toxic changes and vast amounts of protein lost from the burned surfaces and kidneys. Progressive rapid debility occurs in direct proportion to the extent of the exposed burn surfaces. The more extensive the burn the more difficult the process of maintaining physiologic blood levels and the more debilitated the patient becomes. As the exposed areas are resurfaced either by spontaneous epithelialization or skin grafting, diminishing the total exposed body surface, the toxic process is diminished. Erythrocytes are not so rapidly destroyed and proteins are conserved.

Careful medical therapy is essential in attempting to maintain normal physiochemical levels. Once they have been materially lowered it is difficult to elevate them to normal. In extensive burns medical therapy alone cannot maintain normal levels. Spontaneous epithelialization or skin grafting must be in advance of the chemical processes which tend to emaciate the severely burned patient.

EMERGENCY TREATMENT

If the patient is examined at the scene of the injury he is given a quarter or a half grain of morphine sulfate. He is wrapped in clean sheets or blankets. At the hospital additional morphine may be required in order to control the agonizing pain. ACTH, 25 milligrams, and Combiotic[1] should be administered. ACTH will help to prevent shock and will diminish the intensity of the pain. It also makes the patient euphoric and less mindful of the seriousness of his condition. Combiotic[1] will control infection. The patient should be taken to the operating room and the wounds thoroughly sprayed with copious amounts of water or normal saline. Under no condition should the skin surfaces be rubbed to remove dirt particles. A gentle cleansing action may be harmless, but rubbing rigorously enough to remove imbedded or strongly adherent dirt particles will also remove precious epithelium. This will increase the depth and extent of the burn. If a spray cleaning is not advisable or available, the burned areas should be dusted by sulfathiazole powder and covered by Vaseline[11] gauze and a bulky pressure dressing. Secondary operations can always be performed at a later date for removal of the dirt particles. The dressings are not disturbed for ten days.

MEDICAL THERAPY

Careful medical therapy during the first 21 days is essential. Plasma is administered as

an emergency measure to help prevent shock and replace the lost proteins and fluids. Plasma is lost because of the increased capillary permeability. After 48 hours whole blood is substituted for plasma. Initially, in severe burn cases the blood will show a hemoconcentration because of the plasma loss. The total circulating blood volume is diminished. After 48 hours however, the burn toxins destroy erythrocytes and the hemoconcentration is gradually converted into an anemia. Since hemodilution will occur, it is advisable to maintain a mild hemoconcentration to help counteract the inevitable anemia.

Morphine, codeine or Demerol[2] will control the pain. If ACTH is administered the quantity of narcotics required to control the pain is diminished. After the first few days, ACTH alone may control the pain without narcotics. Narcotics, however, are required when the dressings are changed.

Proteins in the form of a high protein diet, gastric tube hydrolysate feeding and intravenous amino acids (Amigen[5]) will help maintain the protein level.

Chlorides and fluids by intravenous solutions of normal saline are necessary. An excellent method of replenishing fluids and chlorides was reported last year in this JOURNAL by Moyer.[3] Instead of drinking water the patients are given a hypotonic salt solution (3 Grams of sodium chloride and 2 Grams of sodium citrate to the liter). For the first few days the hypotonic salt solution causes nausea. However after a few days the drinking solution is well tolerated.

A high protein, high caloric diet is prescribed. It is supplemented by multi-vitamin tablets and iron preparations either by mouth or gastric tube. For additional nutrition 95 per cent ethyl alcohol in 50 cubic centimeter amounts is instilled into the Amigen[5] for intravenous administration. Besides the additional nutritive value, alcohol diminishes pain and gives the patient a feeling of well being.

ACTH is beneficial, sometimes essential, in the treatment of severe burns. It is excellent as a means of allaying pain. Under treatment by ACTH, patients are not apprehensive. They look better and feel better. ACTH did not appear to have any pronounced action either of stimulating or inhibiting epithelialization. Except for a "drying" effect it did not seem to affect wound healing. The "take" of skin grafts was not affected. The patients were well controlled by 25 milligrams every 12 hours. The dose was increased to 25 milligrams every 6 hours but this did not enhance its action. Ten milligrams of ACTH every 12 hours were inadequate.

Infection must be controlled to preserve the viable islands of epithelium in first and second degree burns. If these are destroyed by infection, the wounds are converted into the more serious third degree ones. Combiotic[1] is employed for the first 21 days. It is then replaced by gradual diminishing doses of oral Terramycin.[6]

SECONDARY DRESSINGS

On the tenth day, the patient is taken to the operating room under heavy sedation (morphine grain ½) and the wounds are dressed. General anesthesia is not advocated for the change of dressing as it increases shock and diminishes resistance to infection. Any loose debris or slough is excised. By the tenth day, most of the first degree burned areas will have healed. Second degree burned areas are not healed. At this time one cannot accurately assess the depth of the burns. A striking change in the appearance of wounds is now noted with ACTH. Heretofore the wounds were covered with large amounts of fetid discharge. Now the wounds are dry and odorless. Second degree raw surfaces appear to be epithelialized but actually are not. It is the absence of a discharge on these surfaces which leads to the misconception. The wounds are thoroughly dusted with sulfathiazole powder. Vaseline[11] gauze and a pressure dressing is reapplied.

At this dressing the fingers and hands deserve special attention. Since one cannot accurately differentiate between a second degree and third degree burn, the hands are dusted with sulfathiazole powder and placed in sterile bags so that the fingers have freedom of motion. If the early exercise and manipulation are not practiced, crippling arthritis, stiff

joints and fibrous adhesive bands will develop. Through the "bag" the patients are encouraged to move the fingers. Sterile pillow cases held around the wrist and forearms by elastic bands have served as excellent "bag dressings".

First and second degree burns of the face heal rapidly and satisfactorily because of its excellent blood supply.

The third dressing is performed on the fifteenth day. The extent and seriousness of the burn can be better estimated at this time. If the burn is a third degree one, large areas of "dry" slough and adherent thick crusts are noted. Frequently one observes a mixture of second and third degree granular areas. It is impossible to differentiate second degree from third degree raw areas by mere inspection at this dressing. A good test to differentiate a second from a third degree burn at this time is the "exposure method" of treatment. The questionable areas are exposed to the air. The limb or body is exposed uncovered on sterile sheets under a heated wire cradle. Bed covers are placed over the wire cradle. Second degree burns will heal in 48 hours by this method of treatment. The crusts are strongly adherent to the deeper tissues and are difficult to remove. These crusts mask the under surface. One is not certain of the condition of the areas beneath the crusts.

The fourth dressing is performed on the twentieth day. The patient is heavily sedated with one half to three quarters of a grain of morphine and taken to the operating room. The wounds are thoroughly debrided. The crusts and slough separate easily and are removed. If the exposed areas are clean, simple cold saline continuous compresses are applied. If the area is grossly infected continuous wet dressings of 1 to 3300 aqueous chloroazodin[7] is applied. In one to three days the wounds are ready for skin grafting. As soon as it is certain that grafting is necessary, it should be started. Procrastination and wishful waiting for spontaneous epithelialization is dangerous. At this time the process of inanition is highest. Patients begin to become moribund. Skin grafting must be in advance of the inanition processes.

SKIN GRAFTING

Burns of the maxillo-facial area deserve special attention. Third degree burns of the face, eyelids, nose, mouth, ears and neck must be grafted before the burn scars contract and cause irreparable damage. Unfortunately, burns involving 40 to 70 per cent of the body area must be resurfaced as rapidly as possible as a life-saving measure. In these instances the maxillo-facial areas must, of necessity, be neglected. They are grafted when the patient is out of danger.

The flexor surfaces of the limbs must be grafted first to prevent contractures and permit early ambulation. Thus whole sheaths of split skin (dermatome drums) are applied to the cubital and popliteal fossae. On large flat surfaces dermatome split grafts modelled into squares or strips may be applied.

If skin grafting is delayed, exuberant protective granulations form. These are spongy, friable and bleed with a minimum of manipulation. In limited third degree burns they are best pared down before applying a skin graft. In extensively burned, debilitated, anemic, moribund individuals, marked capillary oozing with the loss of 200 to 500 cubic centimeters of blood will occur if the granulations are removed. Besides the deleterious effect of further diminishing the blood volume, excessive bleeding prolongs and enhances the shock of the operation. In these cases paring is best omitted and the grafts are applied directly to the exuberant granulations. Antiseptics (alcohol, iodine, Merthiolate,[8] and Metaphen[9]) are best not applied to granulations. Granulations which were flat and stable became exuberant after the application of antiseptics.[4]

A rapid non-shocking method[10] of resurfacing extensive, flat surfaces in the moribund patient is to apply the dermatome cement and drape the patient in the operating room without anesthesia. Administer gas and oxygen and cut the grafts (2 to 4 drums of skin may be cut in a few minutes). The anesthetic is discontinued and the grafts are applied without suturing. Vaseline[11] gauze and a pressure dressing with immobilization almost always assures a take of the graft.

Early skin grafting is highly desirous. After

21 days one can usually begin grafting. ". . . . excision of the full thickness wound destruction within the first hours after injury with immediate closure of the wound by split thickness grafts" (Cope[12]) is the ideal treatment. However, rarely can one determine accurately before the fifteenth day the depth of the burn and whether or not it will require skin grafting.

NURSING

Heretofore severely burned patients had to be isolated and treated in separate rooms as an obnoxious penetrating odor was emitted. It was impossible to mask the odor satisfactorily. Under ACTH therapy, however, the odor is considerably reduced.

Good nursing care is essential. The loss of large quantities of proteins in extensive burns predisposes to the formation of bed sores. Unburned areas of the back, back of the ankles at the Achilles tendon, and the heels, must be meticulously washed, alcohol sponged, thoroughly dusted with talcum powder and protected by nursing rings. If attention is not paid to these details, sores will develop.

USE OF ACTH

ACTH is indispensable in the treatment of the extensive burn patient.[13] Heretofore, extensively burned patients ran a continuous daily spiking temperature from 102 to 104 degrees. As grafting continued and the body was resurfaced the temperature spiked to diminishingly high levels. When the body was almost completely resurfaced, the temperature dropped spontaneously to normal. This was the course despite large doses of antibiotics. Under ACTH therapy, the temperature remains flat most of the time.

Large quantities of blood (whole blood transfusions) are required to maintain physiologic blood levels in the critically burned patient. The number of whole blood transfusions required is diminished considerably if the patient is under ACTH therapy. Apparently, ACTH stimulates the production of erythrocytes by the bone marrow.

A striking difference in the appearance of burn wounds is noted under ACTH treatment. Prior to ACTH, burn granular surfaces were usually covered by moderate amounts of a thick whitish exudate. Underneath adherent crusts one would frequently observe large quantities of creamy pus. Under ACTH therapy granulating areas are drier and have a glassy appearance. Unhealed second degree burn areas simulate a healed surface. This may easily lead one to believe that ACTH strongly stimulated epithelialization. Actually it caused retention of the normal granular discharge which simulated healing. ACTH does not appear to have any detrimental effect on large granular surfaces. Exuberant granulations do not readily form which is beneficial to those surfaces requiring skin grafting. Split thickness skin grafts are well accepted and the "take" is normal. If ACTH therapy is discontinued, the excessive exudate on the granular surfaces will reappear.

Proteins are conserved by the administration of ACTH. It is much easier to maintain normal protein levels with ACTH. Large quantities of protein are normally lost in the granular exudate. If the exudate is diminished by ACTH therapy then proteins are preserved.

The putrid penetrating odor of the severely burned patient has diminished considerably under ACTH treatment. Formerly extensively burned patients had to be isolated in private rooms in some remote part of the hospital as it was impossible to mask the odor. Under ACTH therapy the intensity of the odor is reduced because the granular discharge is diminished. The dressings are not heavily permeated with drainage.

Under ACTH therapy critically burned patients do not appear ill. Toxic symptoms are absent. The patients are alert and comfortable. Very early and dramatic ambulation is obtained. The patient's color and appetite are good. It is truly amazing to have patients walking about with vast areas of their body burned.

CONCLUSIONS

1. Combiotic[1] and Terramycin[5] were successful in combating infection in severe burns.

2. ACTH is an indispensable drug in the treatment of extensive burns. In a dose of 25 milligrams every twelve hours, it controls the

symptoms of the severely burned patient.

3. Lesser quantities of whole blood are required in the treatment of extensive burns if ACTH is used. In contrast to the high spiking temperatures formerly found in critically burned patients, the temperature will remain normal if ACTH is employed. The exudate normally present on granular surfaces in burned patients is considerably diminished under ACTH therapy. Thus proteins are conserved and the malodor is considerably reduced.

4. ACTH appeared to neither stimulate nor inhibit normal epithelialization. It does seem to diminish the formation of exuberant granulations. Split thickness skin grafts are well received on the granular surfaces of patients treated by ACTH.

5. Dramatic early ambulation is attained in severely burned patients under ACTH therapy. The color, attitude, outlook and appetite of extensively burned patients is good under treatment by ACTH.

31 Lincoln Park

REFERENCES

1. Combiotic is a relatively new antibiotic preparation manufactured by Chas. Pfizer and Company. It contains 300,000 units of procaine penicillin; 100,000 units of penicillin G. (Buffer) and 1 Gram of streptomycin.
Combiotic is prepared in individual vials for intramuscular therapy, and one ampule is administered one to three times a day, depending upon the severity of the case.
2. Demerol hydrochloride is a brand of meperidine or isonipecaine tradenamed by Winthrop-Stearns, Inc.
3. Moyer, C.: JOURNAL of The Medical Society of New Jersey, 47:529 (1950).
4. Eisenstodt, L. W.: American Journal of Surgery, 78:634 (1949).
5. Amigen is the trade-name given by Mead Johnson and Company to their enzymic hydrolysate of casein.
6. Crystalline Terramycin is a crystalline antibiotic isolated from cultures of *Streptomyces rimosus* and distributed by Chas. Pfizer and Company.
7. Aqueous Azochloramine or Azocbloramid as it is sometimes commonly called is manufactured by Wallace and Tiernan, and is their tradename for the brand of chloroazodin used in this study.
8. Merthiolate is a product of Eli Lilly and Company.
9. Metaphen is a brand of nitromersol distributed by Abbott Laboratories.
10. Eisenstodt, L. W.: American Journal of Surgery, 69:168 (1945).
11. Vaseline is the trademark of the Chesebrough Manufacturing Company for their brand of white petrolatum.
12. Cope, O., *et al.*: Annals of Surgery, 125:1 (1947).
13. Whitelaw, M. J.: Journal of the American Medical Association, 145:85 (1951).

OPHTHALMOLOGIC CONFERENCE

The Annual Clinical Conference of the staff and ex-residents of the Wills Eye Hospital will be held at the hospital on March 21 and 22, 1952. The Arthur J. Bedell lecture will be delivered by Dr. Derrick Vail, Chicago, Illinois. The hospital is at 1601 Spring Garden Street in Philadelphia. All physicians will be welcome.

NEED AN INTERN?

Applications have been made by several English-speaking physicians, graduated from foreign medical schools, who are prepared to accept internships in New Jersey. Interested committees should communicate with Dr. Gerald I. Cetrulo at 234 Mt. Prospect Avenue, Newark 4, N. J.

CHEST DISEASE SYMPOSIUM

Both medical and surgical aspects of chest disease will be discussed at the February 26 meeting of the American College of Chest Physicians (New Jersey chapter). The session will open at 8:15 p. m. at the B. S. Pollak Hospital for Chest Diseases in Jersey City. All physicians are welcome to attend without charge. Cortisone and its relationship to pulmonary diseases will be presented by Dr. David M. Spain, pathologist to the Westchester (N. Y.) County Department of Laboratories and Research. Dr. J. M. Chamberlain of Columbia University Medical School will then review the results of segmental resection in pulmonary tuberculosis. A collation will be served.

THE CLINICAL USE OF CORTISONE AND ACTH*

EXPERIENCE AT THE MOUNTAINSIDE HOSPITAL

Harry Halprin, M.D., Montclair, N. J.

The Mountainside Hospital, Montclair, New Jersey, last year appointed a committee[1] to survey the indications, contra-indications, advantages, precautions and side-effects of ACTH and cortisone. This is a report of the studies made by that committee.

The results here presented include findings tabulated after the patient had left the hospital. Some of these findings come from direct clinical observation, others from personal communication with the referring physicians.

The Committee tried to give the referring doctors free reign in the treatment and follow-up of their patients once the necessary safeguards and initial laboratory work were instituted. When the patient left the hospital, we lost almost complete access to the evaluation of the case. No one is anxious to discuss incomplete cures or even half cures. When a glowing result is forthcoming, we get a complete picture. I must admit, although reluctantly, that complete pictures are obtainable only in cases treated on our wards or by members of this Committee.

Immediate results in most cases were excellent. Results continued to be good as long as the patients were under continual therapy. End-results, however, leave a great deal to be desired.

Even experts have difficulty working with ACTH and cortisone. Whether in medical centers or in hospitals such as The Mountainside, we are all in the same boat. You will be exploring things in your own practice that we do not know about and which perhaps have not been seen by anyone else. You may stumble on the answer to the problem which many physicians working in research centers have been unable to find.

Seventy-seven patients have been treated with cortisone and ACTH (54 cortisone; 23 ACTH).

The diseases for which treatment was instituted are as follows:

Rheumatoid arthritis and osteoarthritis	36
Ulcerative colitis	3
Asthma	3
Burns	3
Leukemia, unclassified	4
Lupus erythematosus disseminata	3
Iridocyclitis associated with glaucoma	2
Psoriasis	2
Dermatitis	3
Gout	2
Multiple sclerosis	1
Boeck's sarcoid	2
Patients whose follow-up therapy could not be traced for various reasons; listed as "questionable"	7

Balance of the figures will represent

(A) readmission of the same patient	
(B) Some patients who received ACTH pre-operatively	6

All known procedures for prevention of toxicity have been employed.

Forty-two patients retained sufficient improvement following discontinuance of the medication.

Average weekly dose has been about 375 milligrams. It varied from 200 to 800 milligrams.

Average duration of treatment has been 1 to 8 months.

Number holding complete remission: 13 or 16 per cent.

Number holding worthwhile improvement: 46 or 59 per cent.

Number of failures: 17 cases or 22 per cent.

Number with toxic effects: one case.

These figures do not permit comparison between ACTH and cortisone because the groups are not comparable in selection of patients or in duration of treatment.

The figures do suggest that with both ACTH and cortisone, there remains a number of patients whose disease is not well controlled; and a few who suffer undesirable side effects.

We are, therefore, interested and concerned

* Read before the medical staff of The Mountainside Hospital, Montclair, New Jersey, December 18, 1951

1. Committee members were: Edward C. Gullord, M.D., Toufick Nicola, M.D., Franklin C. Turner, M.D., and Harry Halprin, M.D. (chairman).

in the search for other substances in an effort to increase the number of patients who can be maintained in remission safely and satisfactorily.

CORTISONE THERAPY OF RHEUMATOID ARTHRITIS

In rheumatoid arthritis and its variants, which include rheumatoid spondylitis (Marie-Strumpell arthritis), juvenile rheumatoid arthritis (Still's disease) and psoriatic arthritis, cortisone seems to be the most satisfactory single therapeutic agent.

To quote the original report of Dr. Hench[2] and his collaborators:

> "Most investigators have viewed cortisone and ACTH as research tools and hesitate to recommend their general use in rheumatoid arthritis. Unless new evidence of untoward reactions appear with prolonged administration, this period is past, and these hormones should be considered practical therapeutic agents in this disease."

As a result of the elaborate laboratory data accumulated during the early use of these hormones and the data derived from them, the physiologic and metabolic effects of continued administration of cortisone have been charted in detail. These effects can now be anticipated and controlled without elaborate laboratory measures.

The laboratory data now required are: urinalysis, complete blood count, and erythrocyte sedimentation rate; also a simple clinical test for determining abnormal amounts of urinary sugar.

These tests should be repeated at short intervals to determine the beneficial effects of the hormone.

Frequent determinations of weight are desirable to detect possible fluid retention.

Long-continued administration of the hormone is necessary to keep the symptoms of rheumatoid arthritis suppressed.

Cessation of therapy in rheumatoid arthritis sooner or later, presages a return of the precortisone symptoms. The hormone does not cure rheumatoid arthritis, but it suppresses the disease as does atabrine in malaria. Cortisone and ACTH do not alter the destructive changes in cartilage and bone produced by long standing disease. Deformities remain unchanged.

During the last three months of use in The Mountainside Hospital, we found that patients could be controlled of their symptoms and satisfactorily maintained by much smaller doses than those recommended in the literature. Instead of starting with the usually recommended 300 milligrams the first day, it is sufficient to use only one-third or even less of this dose and to reduce this quickly to a maintenance dose of 50 or fewer milligrams per day. The therapist should be content to maintain a clinical improvement of about 75 per cent of the pretreatment period.

The smallest average daily dose of cortisone or ACTH necessary to maintain adequate control of the clinical manifestations of the disease should be considered as that patient's maintenance dose. This varies with the individual. I have several patients on no more than 5 milligrams of ACTH per day and they are quite comfortable. With a conservative dose schedule, it is possible to eliminate the danger of missing the development of a masked intercurrent infectious process or unsuspected intra-abdominal condition. In a recent symposium on the subject, one authority[3] said:

"In my personal opinion a patient who is maintained satisfactorily at a level of less than 25 milligrams of cortisone per day probably does not need the hormone." Our experience is at variance with this statement. Even 12½ milligrams per day, or every other day, seems to serve a useful purpose in controlling some patients.

It is wise to interrupt the administration of the drug about every four months to determine the possibility of a spontaneous remission. If symptoms occasionally show exacerbations, it may be advisable to institute "booster" doses for 3 to 5 days, then gradually reduce the daily dose to the previous maintenance dose schedule.

Cortisone finds its greatest field of usefulness in the therapeutic control of rheumatoid arthritis in those patients in whom severe pain, swelling, tenderness, and joint dysfunction prevent the necessary and desirable physio-

2. Hench, Philip S., *et al.*: Archives of Internal Medicine, 85:545 (April 1950).
3. Merck *Symposium*, page 14 (October 1951).

therapeutic measures. Cortisone then makes possible a full program of physical medicine and rehabilitation.

There is suggestive evidence in the literature (and in a small number of patients under our direct control) that when chorionic gonadotrophins are used as supplementary medication with small doses of cortisone or ACTH, there appears to be a synergistic effect producing greater anti-rheumatic activity than when used alone.

When administered by injection, ACTH simply stimulates the patient's own adrenal gland to make cortisone and *cortisone-like* substances; therefore, toxic and therapeutic effects of cortisone and ACTH can be considered together. The differences are less important than their similarities.

We have learned several important facts, however, which have become guides to the further use of these hormones.

1. Cortisone makes the patient retain both water and sodium. If there is any tendency to cardiac decompensation or rheumatic fever, edema is likely to occur. A patient receiving these drugs for more than two weeks should have a low sodium diet (no salt used in the kitchen and no salt shaker at the table).
2. Cortisone promotes the release of potassium in the urine and its deficiency causes:
 a. muscular weakness
 b. abdominal pain
 c. ECG abnormalities
3. It is more difficult to neutralize a potassium insufficiency than to prevent it. We therefore found it advisable to prescribe 3 Grams of potassium chloride every day if cortisone therapy extends beyond two weeks.
4. In treating patients with ACTH and cortisone we must be careful to note that the patient does not have coexisting secondary infection. For example, acute appendicitis in a cortisoned patient, is not likely to give rise to a high leukocyte count until the appendix ruptures.
5. If a patient during treatment with ACTH or cortisone begins to show a high blood sugar and spills sugar into the urine, he has to be treated, much as if he were a diabetic, with diet and insulin. When the hormone is stopped, the hyperglycemia usually clears.
6. Patients who receive these hormones over a long time and begin to show return of symptoms frequently will be helped more by the addition of a little thyroid to their daily regime than by the increase of ACTH or cortisone. They suffer from some degree of induced hypothyroidism although the metabolic rate may be nearly normal. Basal metabolism reports will not show as well as a "radioactive iodine uptake" test.
7. Some of the psychiatric side effects (such as schizoid excitement) may react beneficially, (if the continual use of the hormone is important) by changing from ACTH to cortisone or *vice versa.*
8. The Cushing's Syndrome ("moon-face", acne, hirsutism, pinkish striae) that sometimes occurs is always reversible; but the reversal is relatively slow. If the original symptoms are relatively improved, it is possible to stop the drug. The patient can then be reasonably reassured that Cushing's syndrome will not persist.

LONG-ACTING ACTH GEL

In some cases it may seem necessary to give the drug four or five times a day because it is so rapidly metabolized. There is now being developed[4] an ACTH "Gel", somewhat similar in physical properties to protamine zinc insulin. If this product meets the hopes of its producers, it will be possible to maintain therapy with a single daily injection.

TREATMENT OF BURNS

One of the most important uses so far evaluated is in second and third degree burns. We have one such case in the hospital at the present time who is being treated with ACTH. The following observations have been made:

1. Granulation tissue is not nearly as exuberant as it usually is.
2. Healing of the areas that appeared to have third degree burns seemed to take place from islands that remained where such islands were not expected.
3. Vesicle formation and oozing of body fluid have been conspicuously absent.

The types of disease for which ACTH and cortisone are most effective are those in which the inflammation has an allergic basis and a self-limited cause.

TREATMENT OF RHEUMATIC FEVER

Any patient with acute rheumatic fever should have a course of cortisone or ACTH. We may thus eventually eliminate the incidence of later crippling cardiac lesions. The course of rheumatic fever is unaffected although the control of the most acute episodes may prove of value.

4. By Dr. John Mote and his co-workers in the Armour Laboratories in Chicago.

OTHER USES

1. *Certain allergic skin conditions:* Eczematous dermatitis.

2. *Ophthalmic iritis.*

3. *Gout.* In this disease ACTH or cortisone effects rapid amelioration of symptoms. It is important to supplement the hormone with colchicine and salicylate preparations. For example, the practitioner may start the patient on an initial dose of 50 milligrams of ACTH and follow that up for 2 or 3 days at a rate of about 25 milligrams every four hours; and start colchicine at the same time. In this way, when the ACTH is stopped the patient will not have a serious exacerbation.

ASTHMA

ACTH will do for asthma what it will do for gout. In cases of status asthmaticus, where the patient is epinephrine fast, ACTH will often have a dramatic effect. It gives one some method of handling the worst symptomatic phases of the disease, but will act only as long as the hormone is being administered.

CONCLUSIONS

There are at least three things to know about cortisone and ACTH: (A) When and how to use it as definitive treatment; (B) When and how to use it as a palliative weapon; and (C) When *not* to use it.

A. If a definite diagnosis has been established, use cortisone or ACTH: in Addison's disease, acute iritis, herpes zoster, sympathetic ophthalmia[5] superficial keratitis and other inflammatory diseases of the eye;[5] in burns involving large areas of body surface; in the "hypersensitivity" conditions such as status asthmaticus, drug or serum reaction, or bites of the black widow spider or of certain snakes; and in the acute stages of certain severe skin diseases such as atopic dermatitis or exfoliative dermatitis.

B. These hormones should be considered for palliative treatment in ulcerative colitis, in inoperable malignancy[6] and in collagen diseases such as rheumatoid arthritis, lupus erythematosus disseminata[7] or rheumatic fever.

C. Cortisone and ACTH are *contra-indicated* in active tuberculosis, and in known gastric or duodenal ulcer. Studies have shown definite impairment in the healing of tissue and increased mortality from intercurrent infection. Intercurrent infection is a very real, though usually only potential, danger in patients receiving large doses of these hormones.

145 Union Street

5. If there is a probability of vision being impaired, use of ACTH or cortisone is practically a "must" today.

6. Because it affords relief of pain, improves appetite, produces a general sense of well being and has a generally good emotional effect.

7. A paper on the treatment of lupus erythematosus disseminata with ACTH is now in preparation.

MEDICAL ESSAY CONTEST

The Mississippi Valley Medical Society offers a cash prize of $200, a gold medal and a special certificate for the best previously unpublished essay of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit will be granted to physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association and citizens of the United States. The winner will be invited to present his contribution before the Mississippi Valley Medical Society to be held in St. Louis, October 3, 1952, the Society reserving the exclusive right to publish the essay in its official publication—the *Mississippi Valley Medical Journal.* All contributions shall be submitted in five copies, not to exceed 5000 words, and must be received not later than May 1, 1952.

Further details may be secured from—Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209 W. C. U. Bldg., Quincy, Illinois.

STATE ACTIVITIES

TRUSTEES' MEETING

JANUARY 6, 1952

A regular meeting of the Board of Trustees was held on Sunday, January 6, 1952, at the Executive Offices, Trenton.

The following is a summary of the principal actions taken by the Board at this meeting:

With reference to the report of the Executive Committee of its regular meeting held on November 13, 1951:

The Advisory Committee on Welfare Services was asked to cooperate with Dr. J. F. Pessel, who represented the Society in a preliminary conference with the State Department of Institutions and Agencies, in studying the provisions of Chapter 139, P.L. 1951, for the care of permanently and totally disabled by the use of Federal funds.

Approval was given for the establishment of a committee of liaison between The Medical Society of New Jersey and the New Jersey Hospital Association. The following were named to represent the Medical Society on this new committee: Dr. Henry B. Decker, Chairman, Dr. Elton W. Lance, Dr. William C. Wilentz, Dr. Sigurd W. Johnsen, *ex-officio,* and Mr. Richard I. Nevin, *ex-officio.*

Approval was granted to a recommendation that copies of THE JOURNAL and the Membership News Letter be sent each month to the editors of the twenty-six daily newspapers throughout the state, the costs to be charged to the Public Relations Committee's account.

A request for the opinion of the Society concerning the propriety and desirability of including in the by-laws of a hospital the requirement that physicians must have malpractice insurance to be eligible for staff appointments, was referred for study to the Committee on Medical Defense and Insurance, to be sent subsequently to the House of Delegates without recommendation. Recommendation was also made that the Medical Defense and Insurance Committee combine the above study with its study of physicians' and hospital liability, and consult with counsel on both matters.

The requests of the various advisory committees that medical services be excluded from the Hospital Service Plan and included in the Medical-Surgical Plan were referred for action to the Permanent Committee on the Medical-Surgical Plan.

The appointment of Dr. Louis Wegryn as a member of the Advisory Committee on Hospital Relationships was approved.

Dr. John L. Varriano, Chairman of the Advisory Committee on Pharmaceutical Problems, was designated as the Society's representative on the Planning Committee for the Rutgers Pharmaceutical Conference, scheduled to be held in New Brunswick on May 14, 1952.

Approval was granted to three statements adopted by the Medical-Dental Liaison Committee at its meeting on October 25, 1951.

1. The Committee records itself as strongly affirming the definite need for a grade A medical-dental school in New Jersey.

2. The Committee records itself as united in its determination not to take a stand as favoring one site over another.

3. The Committee proposes a conference dinner meeting of the Medical-Dental Liaison Committee, to which will be invited key state legislators, two deans of selected medical schools, and two deans of selected dental schools, to explore all factors involved in the establishment of the proposed medical-dental school.

Approval was granted for the appointment of Mr. Nevin as the second of the two representatives to which the Society is entitled on the New Jersey Welfare Council, to serve with Dr. Harrold A. Murray, previously appointed by the Board of Trustees.

With reference to the report of the Executive Committee of its regular meeting held on January 6, 1952:

Approval was granted to the recommendation that the whole matter of A.M.A. dues collection be referred to the Medical Practice Committee, with the request that they undertake a study of the advisability of recommending to county medical societies that they include the A.M.A. dues in their billing at county level.

Approval was given to the recommendation that the 1952 Official List be printed in alphabetical order, and that actual publication be delayed to include as many supplemental lists as possible.

Appointment of Dr. Ray E. Trussell as a member of the Special Committee on the Medical School was approved.

Approval was given to the recommendation that the Physician Resources Committee of the State Society be discharged with thanks, as of this day.

A recommendation that the matter of physicians' listings in the classified sections of telephone directories be referred for study and recommendation to the Medical Practice Committee was approved.

The nomination of Dr. David B. Allman, Dr. Joseph F. Londrigan, and Dr. Elmer P. Weigel as candidates for the vacancy on the Hospital Advisory Council occasioned by the resignation of Dr. Frederic J. Quigley was approved.

The Third Workshop in Health Education, under the auspices of the New Jersey Tuberculosis League and scheduled for June 17-28, 1952, was approved, and the Society accepted an invitation to be a co-sponsoring agency.

Dr. Harry C. White, Chairman of the Advisory

Committee on Chest Diseases, was named as the Society's representative to the Workshop Committee.

Subsequent to the report of Dr. J. Wallace Hurff concerning hospital liability insurance, a motion was passed approving the recommendation of the Welfare Committee that physicians be encouraged to carry sufficient malpractice insurance coverage, and that as far as possible like coverage be extended to include hospital personnel.

Approval was granted to two recommendations emanating from the Advisory Committee on Hospital Relationships. The Board approved the recommendation that all general hospitals which are able to give proper care and provide adequate isolation admit cases of polio. The Board approved in principle the recommendation that all medical services be excluded from Hospital Service contracts and be included in Medical-Surgical contracts. A third recommendation that 'when a glaring inequity occurs, the State Medical Society investigate and advise the county medical society under whose jurisdiction the infringement took place to act as arbiter" was rejected and returned to the Hospital Relationships Committee for clarification and resubmission.

Approval was granted to two recommendations of the Advisory Committee on Welfare Services—(1) that two members of the advisory committee be authorized to meet with the interim committee appointed by the Legislature to study the provisions of Chapter 139, P.L. 1951; and (2) that the State Medical Society consider an increase in the fee schedule for the State Board of Child Welfare to $3.00 for an office visit and $4.00 for a house visit.

A resolution offered by the Advisory Committee on Laboratory Medicine authorizing the State Society to sponsor legislation to achieve a statutory definition as to who may give legal consent for post mortem examination of the body of a deceased person was approved. A second resolution sponsored by the Advisory Committee on Laboratory Medicine to sponsor legislation limiting the supervision of clinical laboratories to competent and properly qualified persons was approved, subject to the advice and consent of counsel.

The recommendation of the Advisory Committee on Venereal Disease Control, that the Society take steps to enforce the apprehension of contacts under the "State of War Acts and Subversive Crimes" which makes it possible to arrest and enforce treatment of prostitutes, was approved.

The recommendation of the Advisory Committee on Adult Disease Control that a diabetes detection program under the control of The Medical Society of New Jersey be established and started first as a pilot study was approved.

Approval was granted to four recommendations of the Advisory Committee on Conservation of Vision and Hearing: (1) That the State Motor Vehicle Department be asked to accept a consultant or consultants, recommended by the Medical Society at state level and the county society at local level, to act in an advisory capacity regarding the eye qualifications of drivers. (2) That the Medical Society appoint representatives to the State Board of Education and to local boards to act in an advisory capacity on problems of vision. (3) That the State Department of Education be urged to appoint an ophthalmologist, recommended by the Medical Society, who would be available for consultation on all questions concerning vision. (4) That the Medical Society endorse remedial reading clinics operated under the control of county society committees on conservation of vision, with constant supervision exercised over the activities of those who become teachers in these clinics.

A recommendation from the Advisory Committee on Cancer Control that a requested article on radioisotopes be reprinted in full in The Journal was disapproved.

The Board disapproved the recommendation of the Executive Committee that the Judicial Council act at the state level on disputed medical compensation bills. The Board recommended instead that all these matters be settled at the county level, unless and until the need for a state committee has been demonstrated.

The recommendation submitted by Dr. Elton W. Lance, as representative of the Medical Society on the Subcommittee on Human Biologic Defense, concerning the means whereby the members of the Society could assist in implementing the program, was referred to the Public Health Committee for action and cooperation with the Subcommittee on Human Biologic Defense.

A motion that the Committee on Implementation of the New Jersey Plan be dismissed with an expression of appreciation for the work that they have accomplished was unanimously approved. The Board approved the appointment of a new committee to further study and evaluate the New Jersey Plan, to be composed of the Society's A.M.A. delegates.

In conjunction with the report of the Permanent Committee on Medical-Surgical Plan, the Board reaffirmed its approval in principle of the exclusion of medical services from Hospital Service Plan contracts, and inclusion in the Medical-Surgical Plan contracts.

The Board approved a request of Medical-Surgical Plan that it be permitted to circularize the participating physicians concerning a revision of income limits for service benefits.

The Board approved in principle a recommendation that The Medical Society of New Jersey permit the Medical-Surgical Plan to develop and apply certain qualifications with respect to the eligibility of a consultant for payment of consultant benefits, if the Plan finds it necessary to develop such qualifications, with the understanding that the precise criteria to be applied shall be transmitted to The Medical Society of New Jersey for specific approval.

Approval was given to a recommendation that the Medical Society prepare a citation for presentation at the annual meeting to recognize and commend the various leaders of the profession who organized the Medical-Surgical Plan and have served as members of its Board of Trustees.

Approval was given to the following recommendation submitted jointly by the Advisory Committee on Workmen's Compensation and Industrial Health, and the Special Committee on Temporary Disability Benefits: That the Board of Trustees

request the county societies to initiate systems for naming medical consulants for Temporary Disability Benefits Examinations when necessary, recommending some modification of the system used in Atlantic County, adapted to fit particular needs, as the most efficient means of carrying out this program.

The Board approved in principle the establishment of an educational campaign to encourage physicians and the public alike in the realization of the seriousness of the problem of malingering under this program.

Approval was given to a motion that the Board propose to the Constitution and By-Laws Committee amendments to the By-Laws whereby the publication month of the Official List would be changed, and the basis of representation in the House of Delegates would be the active membership of the county societies on December 31 of the preceding year.

Approval was given to a request of the State Board of Medical Examiners that the Medical Practice Act be amended to permit nine doctors of medicine to serve on the Board of Medical Examiners, instead of "five old school physicians, three homeopaths, and one eclectic", as is now required.

OFFICIAL LIST

Dr. Marcus H. Greifinger, Secretary of The Medical Society of New Jersey, announces that the Official List of Society membership will not be published with the April JOURNAL, as in past years, but at some later date, probably in the early fall, so as to include as many supplemental lists as possible. It is felt that under the present schedule of publication the list does not present a true picture of the membership for the year. After the Official List for 1951 was published, more than 800 additions and changes were made.

OBITUARIES

DR. AIMS R. CHAMBERLAIN

Dr. Aims R. Chamberlain, a retired obstetrician, died on December 27, 1951, at the age of 72.

Dr. Chamberlain obtained his medical degree from Columbia University in 1905, and interned in Mt. Sinai Hospital and Lying-In Hospital in New York. Until his retirement 10 years ago, he was a member of the staff of Orange Memorial Hospital. He was an emeritus member of the Essex County Medical Society and The Medical Society of New Jersey.

DR. RICHARD M. FOWLER

Dr. Richard M. Fowler, 67, died on November 13, 1951, after a lengthy illness.

Dr. Fowler received his medical degree from the University of Pittsburgh in 1913. He served his internship in Kansas City General Hospital and set up practice in Atlantic City in 1916. He was active in community and fraternal affairs.

DR. MORRIS FRANK

Dr. Morris Frank of Bayonne, died on January 1, 1952, after a long illness.

Dr. Frank was born in Minsk, Russia in 1886, and came to Bayonne in 1891. He received his medical degree from Cornell Medical School in 1909, and interned at Bayonne Hospital. He was chief emeritus of the orthopedic department at Bayonne Hospital and was on the staff of Postgraduate Hospital, New York, and Margaret Hague, Jersey City. He was a fellow of the International College of Surgeons.

DR. JOHN F. LOVELL

Dr. John F. Lovell of Irvington, died on December 29, 1951, after a long illness.

Dr. Lovell was born in New Haven, Connecticut, in 1886. He received his medical degree from Boston University in 1908. After practicing medicine in Minnesota, Massachusetts and Connecticut, he moved to Irvington in 1914. He also studied law, graduating from Mercer Beasley Law School, Newark in 1929. In 1926 he was appointed to the Irvington Board of Education, but resigned in 1930 to become mayor (1930-1934).

Dr. Lovell was chief roentgenologist at Irvington General Hospital and had served as chief of staff of that institution. He was also active in civic and fraternal organizations.

DR. JAMES A. MURPHY

Dr. James A. Murphy, prominent ear, nose and throat specialist, died suddenly of a heart attack on December 5, 1951.

Dr. Murphy was born in Trenton in 1904, and received his medical degree from Georgetown University in 1927. After serving his internship in St. Francis Hospital, he opened an office in Trenton. He was a member of the staff at Mercer Hospital for 15 years.

DR. BENJAMIN B. WALLEN

Dr. Benjamin B. Wallen, Wildwood, died on December 4, 1951, at Walter Reed Hospital, Washington, D. C., at the age of 48.

Dr. Wallen had practiced in Wildwood since 1931. He received his medical degree from Syracuse Medical School in 1929. During World War II he contracted a tropical fever. He was active in religious and fraternal organizations in Wildwood.

Medical-Surgical Plan of New Jersey

"New Jersey's Blue Shield Plan"

Medical-Surgical Plan's revised *Schedule of Payments* will be distributed to Participating Physicians shortly after this JOURNAL reaches its readers. The *Schedule* will be incorporated in a durable loose-leaf manual, containing much useful information about Medical-Surgical Plan including its forms and procedures, and its code of regulations. This manual will meet the need of the Participating Physician for a permanent authoritative reference concerning the Plan. As future changes are made in the Subscription Contract, in the *Schedule of Payments* or in other official references, substitute pages will be sent to each Participating Physician for insertion in the appropriate section of the manual. It will be advantageous to each physician to familiarize himself with the manual, and to cooperate with the Plan by keeping his manual up to date in the future.

It is also most desirable that the physician's secretary or assistant become familiar with the mechanics of Medical-Surgical Plan, insofar as they relate to the reporting of professional services. One out of every seven people in New Jersey is now enrolled in Medical-Surgical Plan. Just as the doctor strives to render good medical service to his patients, so also, the Plan desires its service to be helpful and satisfactory to every subscriber and to every physician.

The new *Schedule of Payments* contains a number of changes, both in the general provisions and in the payments for specific procedures. These changes, based upon the recommendations of the profession itself, are designed to bring about more equitable relationships, in respect to the payments provided, among the various types of services and procedures.

The coding of the new *Schedule* conforms to the A.M.A. *Standard Nomenclature* that is in process of adoption by Blue Shield Plans throughout the country. Adoption of the new nomenclature and coding will enable the Plan to compare its actuarial experience with that of other plans, and will promote simplicity and accuracy of records. In addition to the revised nomenclature, physicians will find that the new *Schedule* contains many more items than in previous Plan schedules. Hence, in submitting service reports to the Plan, it is important for the physician to use the precise terminology set forth in the new *Schedule of Payments.*

CLAIM PAYMENTS FACILITATED

Participating Physicians will be interested in knowing that for the past two months, Medical-Surgical Plan payments (except in cases requiring special correspondence) have been mailed to the physician within an average of six days after receipt of the medical service report by the Plan.

OVER 5000 PARTICIPATING PHYSICIANS

More than 5040 physicians are enrolled with Medical-Surgical Plan as Participating Physicians. This represents a net increase of nearly 400 Participating Physicians during the calendar year 1951.

LARGE GROWTH IN 1951

During 1951, Medical-Surgical Plan recorded a net growth of more than 170,000 in the number of persons enrolled in the Plan. This represents a net increase of nearly 700 persons every working day. The medical profession of New Jersey has a right to take pride in the success of the medically-sponsored Blue Shield movement, demonstrating the ability of the profession to meet the basic needs of the people for medical protection through cooperation with labor, industry and the public.

JAMES E. BRYAN, Administrator.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

The State Department of Health suggests that the most significant developments in public health in New Jersey in 1951 were:

1. The general high level of health achieved. Sickness and death rates were generally low. Infant and maternal death rates continued to be low. The incidence of polio was below that of last year. *But,* tuberculosis is still a blot on the state's escutcheon.

Both the case rate and death rate from tuberculosis in New Jersey are far higher than they need or ought to be.

2. Enactment of the Local Health District Act of 1951. This provides the opportunity, not hitherto available, for smaller municipalities to consolidate effectively for strengthened local public health services. It was an essential first step toward stronger local health administration.

3. Organization of the Council for Local Public Health Services of New Jersey. This new organization gives promise of providing a continuing stimulus for development of stronger local health services.

4. The reorganization of the State Department of Health, begun in 1948, was brought near to completion. Three State Health Districts were activated during the year. All four of the contemplated districts are now activated. As the State Health Department's administrative structure is completed and staffed, it will be able to serve local health agencies more efficiently, and New Jersey will be well on the way to a strong, balanced system of public health administration.

Along with these events, there has been training of public health personnel, closer integration of departmental activities, and closer integration with other departments of the state government on matters affecting health.

5. Publication of the New Jersey Plan for Medical and Health Preparedness. The year was landmarked by attainment of a definite organizational form, publication of specific recommendations, and progress in training in medical and health aspects of civil defense. Because this could mean the difference between life and death to large numbers of our people, this could prove to be the most significent public health advance in New Jersey in 1951. It is additionally significant because the planning and organization are such that they can serve in peace as well as in war.

6. Work of advisory committees to the State Department of Health. Progress in the development of codes, strengthened relationships between the department and professional organizations, more effective specialized programs, and other benefits have stemmed from the work of committees advisory to various programs of the department.

7. Promulgation of departmental regulations governing fluoridation of communal water supplies. This was needed before action could be taken in many communities. Fluoridation can affect the oral health of whole generations. Adoption of regulations, therefore, has tremendous significance.

8. Progress made in measuring the adequacy of local health services. By 1951, local surveys to evaluate existing public health services had been undertaken in three counties by local people with technical assistance, upon request, from the State Department of Health. Determination of what is must precede a determination of what ought to be.

Also in the field of local health services, the State Department of Health in 1951 developed a new contractual procedure to provide a grant-in-aid to communities. This reduces departmental bookkeeping, pension, and travel costs. It lessens quality of supervision. It is an inducement for the community to assume the entire obligation by progressive steps.

9. Finding solutions to air pollution problems was pushed with increased vigor. The State Department of Health put into use a mobile laboratory for measuring air pollution on the spot. In cooperation with other groups, plans were made for a statewide conference on the control of air pollution in February.

10. Progress by the Middlesex County Sewerage Authority in establishing a trunk line sewer. Potentially a tri county authority, this movement may change drastically the whole Raritan valley. Pollution of the river and bay will be reduced, property values enhanced, recreational opportunities stimulated, and thousands of persons in the valley will benefit.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, December 14, 1951, Dr. Anthony G. Merendino presiding.

The guest speakers for the evening were Mr. Leon A. Hamilton, counsel for the Provident Mutual Life Insurance Company of Philadelphia, and Mr. Theodore Widing, past chairman of the "Million Dollar Roundtable". Their topic, described as the most timely topic of the year was "Death and Taxes—The Doctor's Dilemma".

The Board of Censors approved for membership Dr. Carl H. Kline, transferring from the Philadelphia County Medical Society.

Dr. Gleason, reporting for both the Hospital Service Plan and the Medical-Surgical Plan of New Jersey, stated that the Advisory Committee of which he is chairman, would welcome any criticism, constructive or otherwise, if it would in any way improve the present working of the plan. He briefly noted some of the changes in the new forthcoming fee schedule of Medical-Surgical Plan and remarked on their fairness and liberality.

Dr. Holland reported on the recently inaugurated Emergency Medical Service Plan. He stated that the service is working perfectly and that no complaints have been received. He again emphasized that the plan was for emergency service only and not for routine relief of physicians who are off call.

Dr. Quinn, at the request of the president, gave a preliminary report on the problem of ringworm of the scalp in school children. He stated that the present incidence of the condition in our local schools is not remarkable, and that the present method of detection and treatment is prob bly sufficient to control the situation. He further added that neither facilities nor personnel were available for the use of the Woods lamps in the detection of scalp ringworm.

Dr. Sasseen reported further on the plan which had been devised for the examination of those Temporary Disability Benefit cases in which treatment had been prolonged beyond a reasonable period.

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

A regular monthly meeting of the *Burlington County Medical Society* convened at the Riverton Country Club on December 13, 1951, at 9:00 p. m., President T. B. Dickson, M.D., presiding.

The scientific program dealt with a few aspects of the cancer problem. The guest speaker was Dr. W. W. Lindenmuth, associate surgeon to the Pennsylvania Hospital. His paper was entitled "Common Lesions and Their Relationship to the Cancer Problem". In a very instructive way, Dr. Lindenmuth outlined the significance of the palpable lump—a frequent finding by the general practitioner. During the discussion which ensued, Dr. T. J. Summey, Superintendent of the Burlington County Hospital, noted the extensive accomplishments attained through the Tumor Clinic of that institution.

A short business session followed and Dr. W. Edward Torrey, Jr. of Moorestown, was elected to membership.

CAMDEN COUNTY

James P. Harbeson, M.D., Reporter

The *Camden County Medical Society* held its regular monthly meeting on January 8, 1952, with Dr. Walter A. Crist, President, presiding.

Drs. Dugan, Grimes and Goos were introduced to the society after taking the oath of membership.

Dr. Hugh Palmer, State Health Director of Haddonfield, urged the members to attend the meeting of the South Jersey Institute of Epilepsy to be held at Kenney's Restaurant on January 11. The scientific program, conducted by Dr. Harold Barnshaw, consisted of three case reports as follows:

1. A Case of Chronic Tophaceous Gout—W. D. Kimler, M.D.
2. Post Partum Inversion of the Uterus—Earl Keller, M.D.
3. A Case of Bilateral Hydronephrosis and Hydroureter Secondary to Exstrophy of the Bladder—Willard M. Drake, Jr., M.D.

The cases were of general interest to the society and were favorably received and discussed.

Drs. Chauncey K. McGeorge, Luke W. Jordan, Joseph J. Blake, Michael E. Nardi, Anthony V. Ziccardi and R. I. Downs were elected to Active membership in the society.

CUMBERLAND COUNTY

Frank J. Aitken, M.D., Reporter

The regular meeting of the *Cumberland County Medical Society* was held at Richards Farm on December 11, 1951, with President E. C. Greene presiding, with an attendance of 35 out of a possible 75. Matters of routine business and interval correspondence were promptly transacted.

The speaker of the day was Dr. Charles H. deT. Shivers, associate professor of Urology at the University of Pennsylvania Graduate School; chief of Urological Department at Atlantic City Hospital. His subject was "Calculus Disease of the Urinary Tract—Diagnosis and Management". It was a fine address by a well informed man.

ESSEX COUNTY

Elizabeth R. Brackett, M.D., Reporter

This society has continued to hold joint meetings with other organizations in accordance with the policy initiated last fall. At each of these meetings our president, Dr. Kenneth Gardner, has opened the meeting, and after the conclusion of the necessary business, has turned the meeting over to the chairman of the Program Committee for that evening. Upon conclusion of the program Dr. Gardner resumed the chair to close the meeting.

On December 13, 1951, our meeting was held at the Academy of Medicine of Northern New Jersey in Newark in conjunction with the Academy of

Medicine. The program was an extremely timely one and provided us with much pertinent information as well as some constructive criticisms and suggestions for improving our individual public relations.

The first speaker, MR. WILLIAM ALAN RICHARDSON, Editor of *Medical Economics,* Rutherford, spoke on the topic "What Is Happening to Private Practice?". The second speaker, MR. JAMES E. BRYAN, Administrator of the Medical-Surgical Plan of New Jersey, spoke on "The Medical-Surgical Plan and Private Practice".

Both speakers are well known to a large percentage of the doctors in the state and have made careful analytical studies of many of our problems. Their remarks carried with them an authoritative and sympathetic attitude, which I am sure provided considerable food for thought to those who had the opportunity to hear them.

On January 11, 1952, our first meeting of the current year was held in the Nurses' Home at Mountainside Hospital, Montclair, in conjunction with the Associated Physicians of Montclair and Vicinity. The talk on this occasion was presented by RICHARD H. OVERHOLT, M.D., clinical professor of Surgery at the Tufts College School of Medicine, who gave a most interesting discussion of "Carcinoma of the Lung", illustrated with some excellent colored slides and statistics. One of the most important factors stressed in his talk was the delay in arriving at the diagnosis of cancer of the lung, and the vital part this delay may play in the results of treatment.

These meetings were both extremely well attended, having two hundred or more physicians in the audience, which is certainly a much larger attendance than we averaged previously when the meetings were all held in Newark.

Following each meeting a buffet supper was provided and an opportunity afforded for discussion among those present.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

Because of the extremely inclement weather, only the hardier members of the *Gloucester County Medical Society* were present at Woodbury Country Club for the meeting on December 20, 1951. With ANTHONY J. DIMARINO, M.D., presiding, the only business accomplished was the election to full membership of RUDOLPH DEPERSIA, M. D. Dr. DePersia is affiliated with the DuPont Corporation and resides in Paulsboro.

The topic of the scientific program was "Psychiatric Problems in General Practice". This most interesting and practical presentation was given by EDWARD T. AUER, JR., M.D., instructor in Psychiatry and Medicine at the Medical School of the University of Pennsylvania. The discussion was opened by William T. Beall, M.D., with practically all of the members present participating.

HUDSON COUNTY

John L. Varriano, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting at Murdoch Hall, Jersey City Medical Center, on December 4, 1951. DR. GLEESON presided.

Dr. Lewis Schwartz, chairman of the Diabetes Committee, reported on the recent Diabetes Detection Drive—which, despite elaborate preparation and extensive publicity, he said, did not arouse public interest to the extent hoped for by the Committee. Dr. Schwartz thanked the members of his Committee, the Hudson County Pharmaceutical Association, the medical directors and the personnel of the various participating hospitals, and all others who cooperated with the Diabetes Committee in any way.

Dr. George Ginsberg, chairman of the Committee for Postgraduate Medical Education, submitted plans for postgraduate study during the month of March 1952. Five lectures covering concepts in the diagnosis and treatment of liver diseases will be presented at the Medical Center on Friday afternoons, from four to five o'clock, beginning on February 29. Dr. Carroll M. Leevy and Dr. Angelo M. Gnassi will be the lecturers.

Elected to Active membership were DR. HARRY C. CODY of Bayonne, DR. RUSSELL W. DORN of Jersey City, and DR. HARRY J. PERLBERG, JR., of Englewood. DR. JOSEPH F. VELLUZZI of Bayonne was reinstated to Active membership.

Dr. John L. Varriano, co-chairman of the Joint Committee for Professional Relations (Hudson County Medical Society and Pharmaceutical Association) issued a stern warning to physicians who may at some time be tempted to violate one or another of the State's recent amendments to the federal Narcotic Law. Violators, he said, are being penalized to the full extent of the law, and cannot plead ignorance. Listed among the most common violations were:

1. Telephoned requests to pharmacists to dispense narcotics on the promise of providing the prescription "later".
2. Failure to include the patient's name and address on prescription.
3. Failure of physician to sign his full name to prescription.

On the scientific program, the guest speaker was DR. HOMER W. SMITH, professor of Physiology, New York University College of Medicine, who discussed "When Does the Kidney Not Make Urine?".

MIDDLESEX COUNTY

F. L. Paret, M.D., Reporter

The annual dinner meeting of the *Middlesex County Medical Society* was held at The Pines, Metuchen, on December 19, 1951.

Following the dinner, the meeting was called to order by the President, DR. MARSHALL SMITH, for the transaction of business.

The financial report rendered by the treasurer showed the Society to be solvent with a balance of $4,294.98 after expenses, not including the annual dinner.

DR. MICHAEL BRODY was elected to Regular membership from Associate membership; and DRS. ROBERT A. BALLOU and THOMAS M. REIN of New Brunswick, and FRANK K. CORBETT of South Plainfield, were elected to a two year period of Associate membership.

The Society was addressed by DR. LEWIS WEBSTER JONES, noted educator and president of Rutgers

University on the subject of "Medical Education in the United States".

Dr. Bartley Howley, chairman of the Committee on the Desirability of Obtaining a Medical School in New Brunswick, reported that the committee was in favor of a Grade "A" Medical School in New Brunswick and had so attempted to influence the State's Investigating Committee.

Dr. John S. Van Mater, chairman of the Public Relations Committee, recommended that the public relations program be expanded during 1952 and particularly to assume an offensive attitude and publicize our research programs, charity work and civil defense programs. It was also recommended that a subcommittee be appointed to deal with local problems; that periodic press meetings be held; that the Woman's Auxiliary be used to aid public relations; that liaison work be done with dental and pharmaceutical societies; and that a professional public relations man be hired to help the expanded program.

Dr. Gerard R. Gessner, chairman of the Committee on Standardization of Emergency Procedures in the care of patients during the first 24 hours following a catastrophe, stated that a written report will be mailed to all members and urged that the recommendations be followed regardless of personal opinion, in order to speed supplies and advance evacuation procedures.

Chairman of the Civil Defense Committee, Dr. Marshall Smith, stated that the recent air raid test was very successful.

The slate of officers for 1952, as presented to the Society by Dr. Martha F. Leonard, chairman of the Nominating Committee, was unanimously elected as follows: President—Charles H. Calvin; Vice-President—Carlyle Morris; Secretary—Raymond J. Gadek; Treasurer—George J. Kohut; Reporter—George M. Benko.

Following a brief address by Dr. Charles H. Calvin, newly elected president, in which announcement was made of the inauguration of post-graduate courses to be held weekly, commencing on Wednesday, January 23, 1952, at Roosevelt Hospital, Metuchen, from 2:00 to 4:00 p. m., the meeting was adjourned.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held in the form of a dinner honoring Sigurd W. Johnsen, M.D., President of The Medical Society of New Jersey, and a member of the Passaic County Medical Society. It was held in the Grand Ballroom of the Alexander Hamilton Hotel on December 19, 1951. The Emeritus Members were guests of the Society.

The business portion of the meeting was dispensed with in view of the occasion. John A. Ianacone, M.D., chairman of the Public Relations Committee and chairman of the dinner, introduced Sandor A. Levinsohn, M.D., President of the County Society, who acted as Toastmaster. Dr. Levinsohn introduced Joseph E. Mott, M.D., Editor of the Passaic County Medical Society Bulletin and chairman of the State Society's Subcommittee on Public Relations, who spoke briefly on the topic of "Public Relations". Frank W. Ash, M.D., chairman of the Building Trustees, was then called on to report on the progress made in remodeling and redecorating the Medical Society Building. He stated that the Medical Society office was then in occupancy on the first floor, and that upon completion of the work the Cancer Society and the Medical Dental Service Bureau would occupy the second floor. A meeting hall accommodating approximately 100 people will be another feature of the first floor. Mr. Richard I. Nevin, Executive Officer of The Medical Society of New Jersey spoke briefly honoring Dr. Johnsen and presenting a biographical sketch of our State Society President. A gavel was then presented to Dr. Johnsen by Dr. Levinsohn, and a bouquet of roses to Mrs. Johnsen. Dr. Johnsen thanked the assembly and spoke briefly on his activities in the County and State Societies.

The scientific session of the meeting was opened by Elias D. Lawrence, M.D., chairman of the Program Committee, who introduced John Garlock, M.D., senior attending surgeon, Mt. Sinai Hospital, New York City and Clinical Professor of Surgery, Columbia College of Physicians and Surgeons. Dr. Garlock spoke on "The Present Status of the Management of Regional Ileitis". His talk was effectively illustrated with slides, and was very well received. After a short period of discussion, the meeting was adjourned.

SOMERSET COUNTY

H. E. Cook, M.D., Acting Reporter

The regular meeting of the *Somerset County Medical Society* was held on December 13, 1952, at the Somerset Hospital Nurses Home.

About 35 persons were present, including several members of the dental profession. This was the first time that the members of our Society and the Dentists had met jointly.

Dr. Irving Klompus, the president, introduced the first speaker, Mr. William Seligman, District Supervisor of New Jersey Rehabilitation Commission, who talked on the purposes and the activities of the Commission.

Victor Levitz, D.D.S., President, State Board of Dental Examiners, then reported on his recent trip to England and his study of the English system of dental care under socialized medicine.

Dr. Theodore Richart, D.D.S., was the next speaker. He explained the School Dental Health Program presented to the Board of Education of Somerville. After his talk it was voted by the Society to approve the program sponsored by Dr. Richart as chairman.

Mr. Howard W. Dayton, Executive Director, New Jersey Heart Association, Inc., then talked on the work of that Society. He sought our support and help in forming a County Chapter. After some discussion it was decided a committee be appointed to submit a report on such a local chapter before any approval be given by the County Society.

Next on the agenda of a busy evening was a discussion of the incorporation of the Judicial Committee as the judicial body of the Society, and as such be incorporated in the by-laws of the Society. Further discussion of the above is planned for the next meeting before acceptance.

UNION COUNTY

Leslie M. Townsend, M.D., Reporter

The January meeting of the *Union County Medical Society* was called to order by the president, DR. LOUIS S. WEGRYN, at the Johnson and Johnson Auditorium in Cranford on January 9, 1952. The main feature of the evening was a panel presentation on "Tax Problems".

The first speaker was MR. SAMUEL BALTER, C.P.A., of Elizabeth, New Jersey, who spoke on *Social Security Taxes*. Mr. Balter traced the historical development of the social security tax provisions and outlined in detail the type of work and the wage and hour requirements for inclusion under this law. He emphasized in particular the fact that any part time domestic or office aide who worked 24 days or received more than $50.00 in any three month period should be included under the provisions of the act.

The second speaker was MR. HENRY C. FOEHL, Trust Officer of the Union County Trust Company of Elizabeth, who spoke on *Inheritance and Estate Taxes*. Mr. Foehl differentiated the various provisions of the New Jersey Inheritance Tax from the Federal Estate Tax and spoke of the advantages to be obtained by using a trust agreement executed before death with the professional counsel of a lawyer and a qualified trust officer for any estate of $100,000 or over.

The third speaker was MR. JOSEPH B. PANTELL of Blair, Rollins & Co., of Wall Street, New York, who spoke on *Investment Problems of the Physician*, emphasizing in particular the advantages of mutual investment funds.

During the course of a short business meeting which preceded the program the Society voted to approve in principle the program of the Association of American Physicians and Surgeons.

Before adjournment the following new members were elected to the Society: ARTHUR W. CULBERSON, PETER KONYHA and SIDNEY G. PINES, of Plainfield; and STEPHEN S. HALABIS of Linden. The following were accepted as transfers: ROBERT G. ECKHARDT of Linden from the Essex County Medical Society; WILLIAM J. CLARKE, JR., of Summit, and MAX M. PUSIN of Union, both from the New York State Medical Society.

N. J. NEUROPSYCHIATRIC ASSOCIATION

J. Lawrence Evans, Jr., M.D., Secretary

On December 19, 1951, the New Jersey Neuropsychiatric Association held its sixteenth Annual Meeting. Feature of the evening was the address of the retiring president, Dr. Crawford N. Baganz. Dr. Baganz spoke on "Criteria for Social Maturity". Election of officers was then held, with the following results: *President*, Dr. David J. Flicker, Newark; *President-Elect*, Dr. Archie Crandell, Greystone Park; *Secretary*, Dr. J. L. Evans, Jr., Englewood; *Treasurer*, Dr. Frank Pignatoro, Red Bank; *Trustees*, Drs. Crawford Baganz, Evelyn P. Ivey, Harold S. Magee, Ira Ross, Mason Pitman, Thomas Fitch and David McCreight.

NEW JERSEY PROCTOLOGIC SOCIETY

Saul Zager, M.D., Secretary

The fourth annual dinner meeting of the *New Jersey Proctologic Society* was held at the Down Town Club in Newark on December 11, 1951.

DR. HARRY E. BACON, Philadelphia, delivered the Joseph M. Mathews Oration, the subject being "Extended Resection for Cancer of the Rectum". This paper was discussed by DR. GARNET W. AULT of Washington, D. C., and DR. GEORGE T. PACK of New York City.

The following officers were elected for 1952: President—DR. URBAN R. FINNERTY, Montclair; Vice-President, DR. WILLIAM A. H. SCHEFFLER, Camden; Secretary—DR. SAUL ZAGER, Newark; and Treasurer—DR. IRVING G. LARKEY, Newark.

AUXILIARY REPORTS

Atlantic County

Mrs. Harry Goodman,
Chairman, Press and Publicity

The December 1951 meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held in the Traymore Hotel, on the 14th, with Mrs. Matthew Molitch presiding. Following a brief business meeting Mrs. Morton Major, Membership chairman, welcomed four new members to the Auxiliary. Mrs. F. Rolfe Westney, chairman for the evening, presented an amusing play, appropriate to the holiday season. The play "The Day After Christmas", was directed by Mrs. Westney and the members in the cast included Mrs. Leonard Ellenbogen, Mrs. Max Gross, Mrs. Daniel Wilner, Mrs. Jay Mishler, Mrs. G. Ruffin Stamps, Mrs. Emerson Burkhardt and Mrs. Anthony Merendino. A pleasant surprise was the appearance of Santa Claus bearing gifts for all. The County Medical Society members were guests for the evening.

A regular meeting of the Auxiliary was held at the Traymore Hotel, January 11, 1952. Mrs. Matthew Molitch, president, presided.

All members of the Auxiliary are urged to attend the Community Day Tea, Tuesday, February 19, at the Strand Hotel. The Tea is a jointly sponsored affair with the Women's Club. Mr. Richard Nevin, Executive Officer of The Medical Society of New Jersey, will speak on "Medical Practice—A Changing Picture".

Mrs. Milton Ackerman has been appointed to the executive board of the Auxiliary.

Mrs. Samuel Kaman, chairman for the Annual Dance reported that all plans are completed for what promises to be a very successful affair. The dance will be held in the American Room of the Traymore Hotel on January 26. Joe Stern and his orchestra will provide the music.

The Auxiliary and guests were then honored by having Dr. and Mrs. Ruby present a musical program. Both Dr. and Mrs. Ruby are well known throughout Atlantic City; Dr. Ruby is heard over station WMID every Sunday morning as Victor Travis. He was also honored last year by being elected to the American Musicological Society.

Cape May County

Mrs. Paul Yingling, Publicity Chairman

At the regular meeting of the *Cape May County Medical Auxiliary,* held on January 15, 1952, Mrs. Clarence Whims of Atlantic City, state chairman of Nurse Recruitment, was guest speaker. She gave a very interesting and informative talk about the many advantages of a nursing career, as well as the great need for more registered nurses.

Our Auxiliary is urging the placement of *Today's Health* in more waiting rooms, beauty shops and libraries, as well as homes, through organizations and individuals.

Films on rural health have been shown to groups in the county and have been well accepted.

Our president, Mrs. William Doebele, explained the purpose and advantages of the Society for Widows and Orphans of Members of The Medical Society of New Jersey.

Essex County

Mrs. Louis L. Covino,
Chairman, Press and Publicity

Members of the *Woman's Auxiliary to the Essex County Medical Society* acted as hostesses at the joint meeting of the Academy of Medicine and the Essex County Medical Society at the Academy of Medicine in Newark on December 13, 1951. The presence of the Auxiliary at the joint meeting was due to the request of Kenneth Gardner, M.D., President of the Essex County Medical Society, and will be repeated at other meetings. Representing the Auxiliary on that night as hostesses at a catered buffet supper immediately following the business were Mrs. John Torppey, President, Mrs. Jesse Glazier, Mrs. Kenneth Gardner and Mrs. Thomas Santoro, Reception chairman.

Mrs. Lucien Della Fera, Booth chairman, and Mrs. Daniel Kavanaugh, co-chairman, with the help of other faithful Auxiliary members, covered the Polio Booth in downtown Newark during the Polio Drive.

Congratulations to Mrs. Frank Forte of Newark, who has been nominated as President-Elect to the Woman's Auxiliary to The Medical Society of New Jersey.

Monmouth County

Mrs. Donald Bowne,
Chairman, Press and Publicity

Instead of a regular December business meeting the Auxiliary combined efforts with the Medical Society to present our Third Annual Holiday Dinner Dance. This was held on December 27, 1951, at the Spring Lake Golf and Country Club. Mrs. Richard Albright was Auxiliary chairman for the event. Attendance was excellent and the evening highly successful.

BOOK REVIEWS

Surgery of the Stomach and Duodenum. By Claude E. Welch, M.D. Pp. 349. Chicago, The Year Book Publishers, Inc., 1951. ($8.50)

The author has done a fine piece of work in condensing into one small volume the many surgical procedures performed upon the stomach and the duodenum. Although there is nothing new in this book, it is up to date and the simplicity of presentation and the omission of controversial discussions will appeal to those who want a quick review before going to the operating room. More than one-quarter of the volume is devoted to drawings which are clear and adequately visualize the technical procedures described in the text. The descriptions of the various steps of each operation are concise and very readable. Though this is designed to be a handbook of operative technic, some of the important highlights in pre- and postoperative management are also included as well as the management of some of the major complications. This volume should have considerable appeal to the surgical resident and the busy junior intern and, therefore, will be a valuable addition to every hospital library.

Henry Reich, M.D.

The Changing Years; What to Do About the Menopause. By Madeline Gray. Pp. 224. Garden City, New York, Doubleday & Co., Inc., 1951. ($2.75)

The emotional, psychological and physiologic changes which occur at the onset of menopause constitute the subject of this book. It explodes the notion that something dreadful and dramatic suddenly strikes the woman and changes her whole outlook on life and her relationship with her husband and children. As the author explains, the menopause is only one of the stages in the growth and development of the organism from infancy to old age. The onset of menopause is gradual and unnoticed by most women, particularly those who are occupied professionally or have community interests or hobbies. Those who suffer with unpleasant symptoms benefit from hormonal and other types of therapy. The fear of estrogens as a possible causative factor in malignancy is also exploded. The status of sex hormones' relation to cancer is touched upon, and the opinions of authorities on the subject are quoted. The administration of estrogens for the relief of menopausal symptoms in properly selected cases is harmless and certain

rules for estrogen therapy are here set down. These recommendations should have been omitted from the book, as directions should come from a physician and not from a popular book to the laity. In patients in whom estrogens are contraindicated, androgens can be used. The rationale of this form of therapy is set forth.

The problem of handling adolescent children with their natural rebellious outbursts has always been a challenge to parents. For the mother, the problem becomes more difficult at menopause because it coincides with the age when children wish to assert themselves, become independent and resent guidance.

The author explains this as normal psychological and emotional growth in the young and gives suggestions for avoiding friction between parents and children.

The physiologic maturation of a woman, menstruation, sex-life of a mature woman, child bearing and fertility are discussed with clarity, simplicity and delicacy in this fine book for the laity.

RITA S. FINKLER, M.D.

A Text-Book of X-ray Diagnosis. By British Authors in Four Volumes. Edited by S. Cochrane Shanks, M.D., and Peter Kerley, M.D. 2nd Edition. Pp. 702. Philadelphia, W. B. Saunders Company, 1951. ($15.00)

This excellent work has been expanded in its second edition from the original three to four volumes. Volume 2 is concerned with the cardiovascular and respiratory systems, and is a worthy successor to the first edition. The authors have included most new developments in cardiovascular roentgenology such as angiocardiography, to the extent of their limits of space. The basic dynamics of pulmonary physiology and pathology are stressed in the section on the respiratory system.

The illustrations are excellent, and the text lucid. Adequate attention is given to the clinical aspects of the disease demonstrated roentgenographically. The text also describes many of the variations of each entity which have been pointed out by other authors. This gives a very complete discussion of even uncommon diseases. The entire set is recommended as an excellent text for all those interested in roentgen diagnosis of diseases of the chest.

JULES H. BROMBERG, M.D.

Chest X-ray Diagnosis. By Max Ritvo, M.D. Pp. 558. Philadelphia, Lea & Febiger, 1951. ($15.00)

Radiology, one of the youngest branches of medicine, progresses so rapidly that a new and up-to-date text book is always welcome. This is particularly true when the book is of the calibre of this one. It is written in a simple, and logical style with a high degree of scientific accuracy. Illustrations are numerous, well selected, and reproduced with diagnostic quality. Technics are lucidly described and important tables are conveniently included. The book is interesting to read and valuable to own for reference purposes. It is of special interest to cardiologists, radiologists, physiologists, bronchoscopists and chest surgeons as well as of general medical interest.

One of the most important aspects of this book is the breadth of viewpoint established in each of the clinical entities discussed. The radiological diagnosis is considered from a background of the disease as a whole. The pathologic and clinical aspects of each subject are well discussed and integrated with the x-ray findings.

It is not the aim of the book to attempt to teach x-ray to the uninitiated, but rather to classify, clarify, and bring up to date the present knowledge and thinking on this subject. When the x-ray findings are not in themselves diagnostic, no attempt is made to establish a link between a definite x-ray appearance and a specific pathologic condition. In such cases, the roentgenogram is described and the differential diagnosis discussed. A mature and scientific attitude is followed throughout the book and renders it a very valuable addition to our medical literature.

CARYE-BELLE HENLE, M.D.

Surgical Practice of the Lahey Clinic. Pp. 1014. Philadelphia, Saunders, 1951. ($15.00)

The surgeons of the Lahey Clinic have here assembled (and revised) articles previously published by them in the various medical and surgical journals of the country. An anthology like this has one advantage over the scattering of the same material in numerous publications. Articles represent a piece-meal approach. Any issue of the average journal offers only a few tidbits of information, and the scatter of the subject may be confusing. Often the reader feels he has no solid ground to hold on. Hence a book like this fills a real need, because the material is well organized, "solid", and readily referred to.

All aspects of surgery are covered. There is material here on neurologic surgery and on the biliary tract; on thyroid surgery and on cardiovascular operations; on the spleen, the adrenals, the breast, the esophagus, the joints, the pancreas, and of course, on all phases of abdominal and gastrointestinal surgery. All in all, it is a compact, home-study, graduate course in surgery. Plates, charts, drawings, diagrams, and other study-aids are vividly and accurately presented. Nor is the book confined to the mere mechanics of technic. This is a good deal of valuable, well-written material on the handling of the patient as well as on the handling of his illness.

CARL P. GUZZO, M.D.

How to Improve Your Sexual Relations. By Edwin W. Hirsch, M.D. Pp. 64. Chicago 6, Illinois, Zeco Publishing Company. Sold through physicians only at 50 cents a copy.

It had to come sooner or later. We have books on how to improve your golf, your bridge, your public speaking, your x-ray technic, and your letter-writing. Some one was bound to see the need for a manual on how to improve your sexual relations. Dr. Hirsch is to be complimented on his unwillingness to exploit this through the—shall we say—lay press, and to confine it to sale among

physicians and issuance by prescription, as it were. The brochure discusses the anatomy and physiology of the genitalia, the various positions for coitus with the advantages and disadvantages of each, the methods for treating premature ejaculation and other barriers to adequate sexual satisfaction. He is aware of the importance of the psychic factor, and is constantly reassuring the reader, seeking to allay senses of inadequacy that arise for so many trivial reasons and are so important in interfering with full sexual pleasure. Here and there he gives vent to a few crotchets which, though probably ineffective, are harmless. (I doubt, for example, if breathing exercises will really help the man who suffers from premature ejaculation, but Dr. Hirsch recommends deep breathing to assure relaxation and thus prolong the erection.) Apart from these few whimsies, the doctrine is sound, and a family doctor may find more than one patient gratified at being given a personal copy of this little book. Come to think of it, it might even make a good wedding present, inexpensive, but probably more valuable than some of the more conventional gifts. And think of the interest it would arouse, displayed on the gift table during the wedding reception!

VICTOR HUBERMAN, M.D.

Environment and Health. U. S. Public Health Service Publication Number 84. U. S. Government Printing Office, Washington 25, D. C. Pp. 125, 1951. ($0.75)

Man's health is wedded to man's environment. Control of air and water pollution, of pests, of milk and food, of garbage and sewage disposal, are all basic elements in any public health program. This attractively printed and vividly illustrated book presents the fundaments of health ecology in a style that is appealing to the sophisticated layman, without being patronizing or scientifically inaccurate. Included is a discussion of the administrative organization of the U.S.P.H.S., tangential reference to organizations of state health departments, and an interesting explanation of research methodology in the public health field. The book is suitable for the health reading lists of college and senior high school students, and as a source-book for any physician called on to lecture to lay groups.

JOSEPH SANTANGELO, M.D.

Psychosomatic Gynecology. By William S. Kroger, M.D., and S. C. Freed, M.D. Pp. 503. Philadelphia, Saunders, 1951. ($8.00)

It should be obvious—but apparently it isn't—that no doctor can treat a gynecologic condition without also understanding and treating the psyche of his patient. The emotional components of gynecologic disease, and the gynecologic manifestations of emotional disturbances are both well known to the experienced and mellow practitioner. But so far as this reviewer knows, this is the first time that such knowledge has been boiled down, clarified and spelled out within the covers of a book. In addition to a good coverage of gynecology, the authors have also devoted attention to obstetrics (including even an interesting review of psychosomatic aspects of the fetus *in utero)* and to neuro-endocrinology.

The text is lucid enough to be understood by the practitioner who has had no advanced training in either psychiatry or gynecology. All it asks of the reader is a good general background in medicine plus an open mind, a willingness to learn about emotional components in gynecologic disease and an interest in human beings. Format and type are excellent. Numerous case studies point up the authors' explanations. The book is well organized and interestingly written. It is useful to the internist, the gynecologist, the obstetrician, the psychiatrist and, above all, to the family doctor.

J. JAY ROMMER, M.D.

Textbook of Refraction. By Edwin F. Tait, M.D. Pp. 418. Philadelphia, W. B. Saunders Co., 1951. ($8.00)

Dr. Tait has written something new in ophthalmic text books by combining in one volume a thorough discussion of all aspects of refraction with a complete review of the diagnosis of non-surgical treatment of ocular muscle anomalies. The subject is complex and the style of presentation is not simple; but the volume is filled with valuable material on almost every page. Every topic is treated carefully and completely. To each chapter is appended an impressive bibliography. Dr. Tait has done constructive original work on refraction.

The texts of Thornington and Maxwell on refraction give a much more simple treatment of the subject, and for this reason are perhaps better suited to the beginner. Dr. Tait's book is of far greater stature than either of these and deserves a place as a complete and up-to-date source of material in the library of every ophthalmologist.

JONATHAN L. HARRIS, M.D.

Biological Antagonism. By Gustave J. Martin, Sc. D. Pp. 516. Philadelphia, Blakiston Co., 1951. ($8.50)

This scholarly treatise perhaps could have better been titled "Biochemical Antagonism", as it is a thorough review of metabolic displacement in enzyme systems. It reviews the subject of natural and synthetic displacing agents in relation to amino acids, chemotherapeutic and antibiotic drugs, pyrimidines, minerals, hormones and vitamins. (The last two are more commonly known as anti-hormones and anti-vitamins.) Each topic is covered completely, from the points of view of the various chemical entities involved, and the kinetics of each enzyme reaction.

Finally, Dr. Martin embraces the whole field in a theory of "biological relativity" which summarizes the subject matter of this volume.

This book will be of most interest to the research biochemist and pharmacist, and will be of limited appeal to the general practicing physician, unless he is extremely well versed in the field of biochemistry.

ROWLAND D. GOODMAN, 2nd, M.D.

Volume 49
Number 2

TUBERCULOSIS

ABSTRACTS

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV February, 1952 No. 2

TREATMENT OF MINIMAL TUBERCULOSIS

Julia Jones, M.D., The NTA Bulletin, September, 1951.

All pulmonary tuberculosis is minimal in its early stages and progression may be avoided by effective treatment. Minimal disease is usually unaccompanied by symptomatic illness so is frequently demonstrated only by roentgenogram. The discovery of disease in its early and curable forms is one of the purposes of case-finding programs. While the wisdom of these programs is established, they fall short of complete accomplishment unless subsequent treatment is effective. Once minimal disease has been identified, its progression must be accepted as failure.

Because the lesions are small and the patient has few, if any, symptoms, one is tempted to attach less significance to minimal disease than to the advanced disease. Rather than to reassure himself and the patient by thinking of "just a little spot on the lung," the physician needs to consider the lesion as the focal area from which disabling disease may occur and, to take advantage of the opportunity for simple, less costly, and more effective treatment.

Individuals vary in their ability to heal tuberculous infection. The majority of those first infected with the disease remain well and infection is indicated only by reaction to tuberculin. Small areas of calcification may appear eventually in lung or lymph nodes. In others irreversible damage occurs, and necrotic tissues may liquefy and slough into nearby bronchi and healthy lung. While the patient may be without symptoms, the X-ray reveals small shadows of pneumonic disease and a "minimal" lesion is diagnosed. The patient may then develop sufficient resistance to prevent further extension. In this case, he either remains well or may harbor areas of chronic infection which undergo evolution after considerable lapse of time.

Except by hindsight, it is not possible to distinguish between the individual who can control his minimal lesion without treatment and the patient in whom progressive disease may occur. This often proves costly for the patient and the community. Since some undetected lesions are controlled without treatment, residual shadows may later be encountered in routine X-ray examinations. For this reason various factors including the pathologic age and character of lesions discovered in asymptomatic individuals need consideration before treatment is advised.

Previous X-ray examinations may demonstrate that the lesion is newly acquired and must be assumed active and unstable. Symptoms or the presence of tubercle bacilli in sputum or gastric contents may indicate activity. In adolescents and young adults, most minimal disease is recently acquired and quite unstable. While new disease may be acquired throughout life, lesions occurring in older persons may represent old unidentified disease needing only periodic examination. Lesions must be subjected to clinical scrutiny establishing their duration and potentialities. From these studies will emerge those patients with early, minimal disease. Effective treatment of this group constitutes the major problem in dealing with minimal disease.

Early lesions are small areas of tuberculous bronchopneumonia which may resolve completely, leaving essentially normal lung tissue. On the other hand, the tissues within this area may be destroyed leaving cavities from which dissemination may occur. Even in the smallest lesion demonstrable by X-ray, some areas have undergone

destructive changes. The outcome of any case depends upon the extent and character of the disease, individual factors of resistance, and the manner in which the latter are influenced by treatment.

The therapeutic program is developed from the following considerations. Since the minimal lesion represents recent extension of disease from microscopic foci of greater duration, it must be assumed that the patient, at this stage, has inadequate resistance to control his disease. Treatment must be directed toward increasing resistance. Much of the lesion may be reversible if the lesion has been discovered soon after it has developed. Immediate treatment is urgent before further evolution produces less reversible lesions. If further extensions of disease take place, each new lesion has potentialities for breakdown and further dissemination. The presence of small necrotic foci must be assumed in all minimal lesions and their extent limits the effectiveness of cure.

Rest is the foundation of the therapeutic program. Experience indicates that rest favors development of resistance, thus enabling the tissues to suppress activity of the tubercle bacillus, remove products of inflammation, and to control areas more permanently damaged. Spreading disease occurs less often when patients are in bed. Bronchial secretions are decreased during bed rest, and this factor probably plays an important part in decreasing the hazard of dissemination through the bronchi.

Bed rest is most effective during the early period of treatment when the lesions are reversible and most unstable. For this reason, it is advocated that patients with early lesions be put to bed immediately upon identification of their lesions. Often this is difficult since the patient feels well. Compromises which permit him to continue his normal activity while the lesion is observed, may jeopardize his future health and happiness.

It is difficult for an asymptomatic individual to make the transition from an active life to complete rest. Given thorough understanding of his problem and the odds at stake and given day to day assistance in meeting the aggravations of inactivity, the usual patient is less unhappy from his treatment than from a set-back of progressive disease. An intelligent individual is able to accept the depressing aspects of tuberculosis infection and inactivity. Recognition of individual problems is necessary and special assistance may be needed.

It seems wise to continue bed rest until stability of the lesion can be assumed. This implies absence of constitutional symptoms and an unchanging lesion by roentgenogram. Clearing of reversible elements occurs usually in from four to six months. Subsequent change by X-ray may be slight and quite slow. From this point treatment is directed toward control of more permanently damaged areas whose presence must be assumed. The time necessary depends on the patient's clinical course, personal situation, and anticipated demands of his normal activities. Resumption of activity must be gradual since bed rest is deconditioning.

In some cases, the administration of streptomycin and para-aminosalicylic acid may be wise. But bacterial resistance may develop and, since the minimal lesion is potentially the advanced lesion, an effort must be made to conserve this temporary support for urgent needs.

Most patients recover permanently from minimal disease if rest is adequate. A few develop more chronic disease which continues to threaten health and in this group it may occasionally be necessary to add collapse or other surgical therapy.

Effective treatment of minimal tuberculosis must be prompt and thorough. The patient must be thoughtfully taught about his disease if full cooperation is to be achieved. Most patients recover completely and resume their previous activities, but needs for vocational retraining must be visualized. Regular medical supervision wisely continues after recovery and resumption of normal living.

ACADEMY OF MEDICINE, NEWARK

WEDNESDAY, APRIL 2, 1952, 8:30 P. M.

Panel Discussion:

THE PRESENT STATUS OF BCG VACCINATION

H. McLeod Riggins, M.D.
Columbia University — Bellevue Hospital, New York

Joseph D. Aronson, M.D.
University of Pennsylvania—Henry Phipps Institute, Philadelphia

Herman Hilleboe, M.D.
Commissioner, State Department of Health, New York

Johannes Holm, M.D.
State Serum Institute, Copenhagen

D. J. Ottenberg, M.D.
U. S. Public Health Service

Arthur B. Robins, M.D.
New York Department of Health

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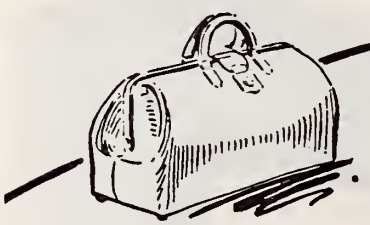
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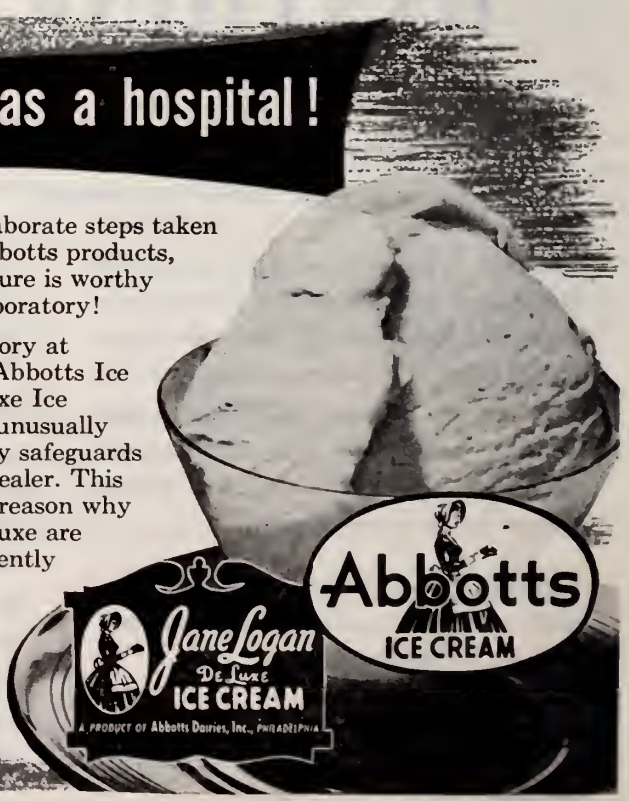
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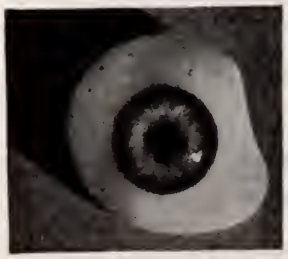
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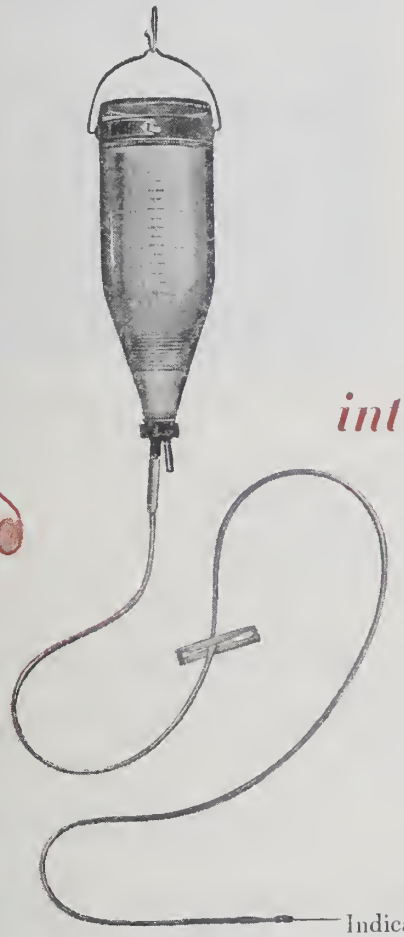
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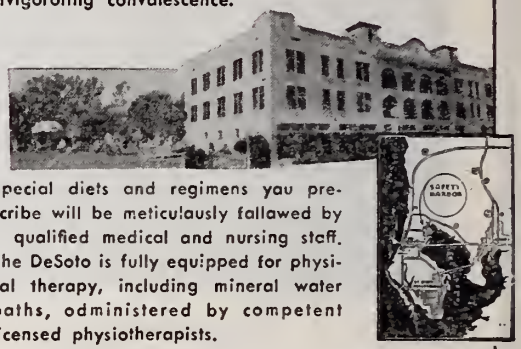
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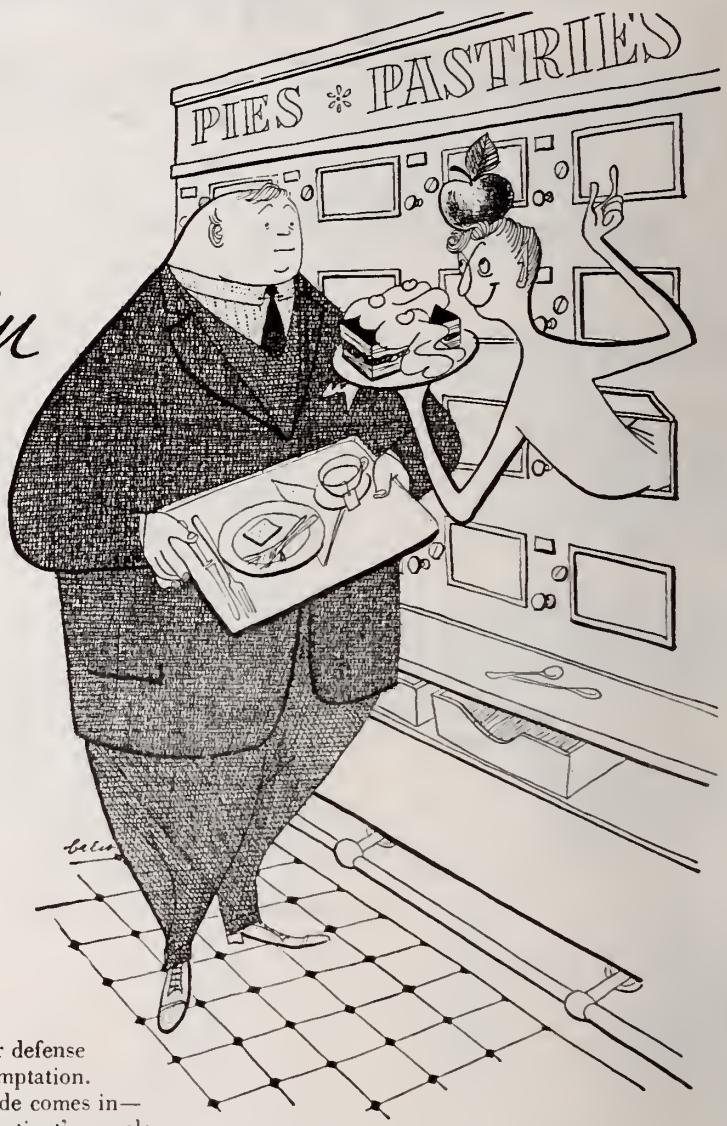
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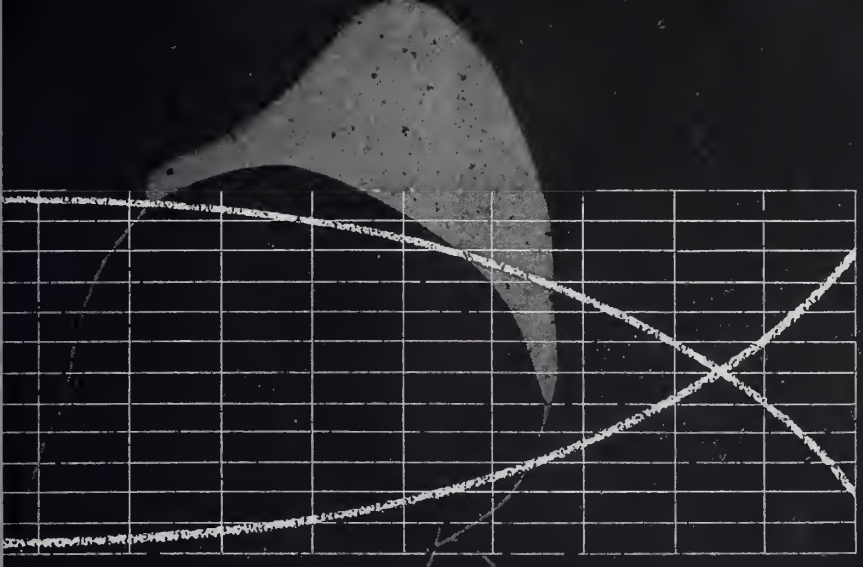
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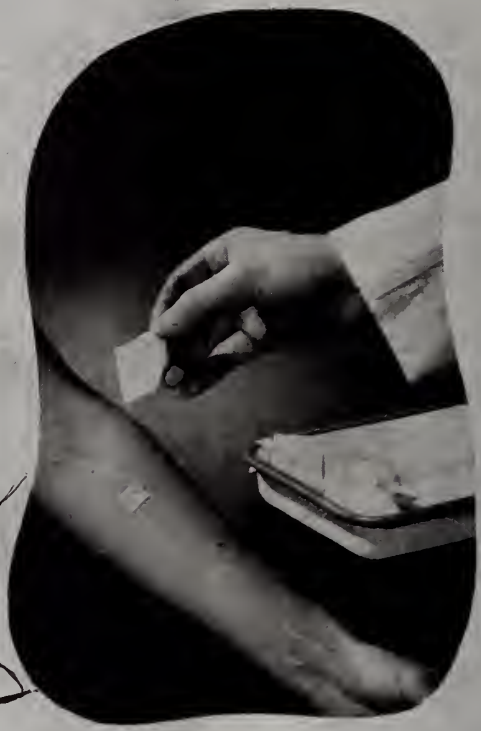
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**J. Pediat. 39:325, 1951*

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1. From Burton Stevenson's "Home Book of Proverbs, Maxims and Familiar Phrases:" Macmillan Co., 1948, p. 2028.
2. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293-299, Sept., 1949.

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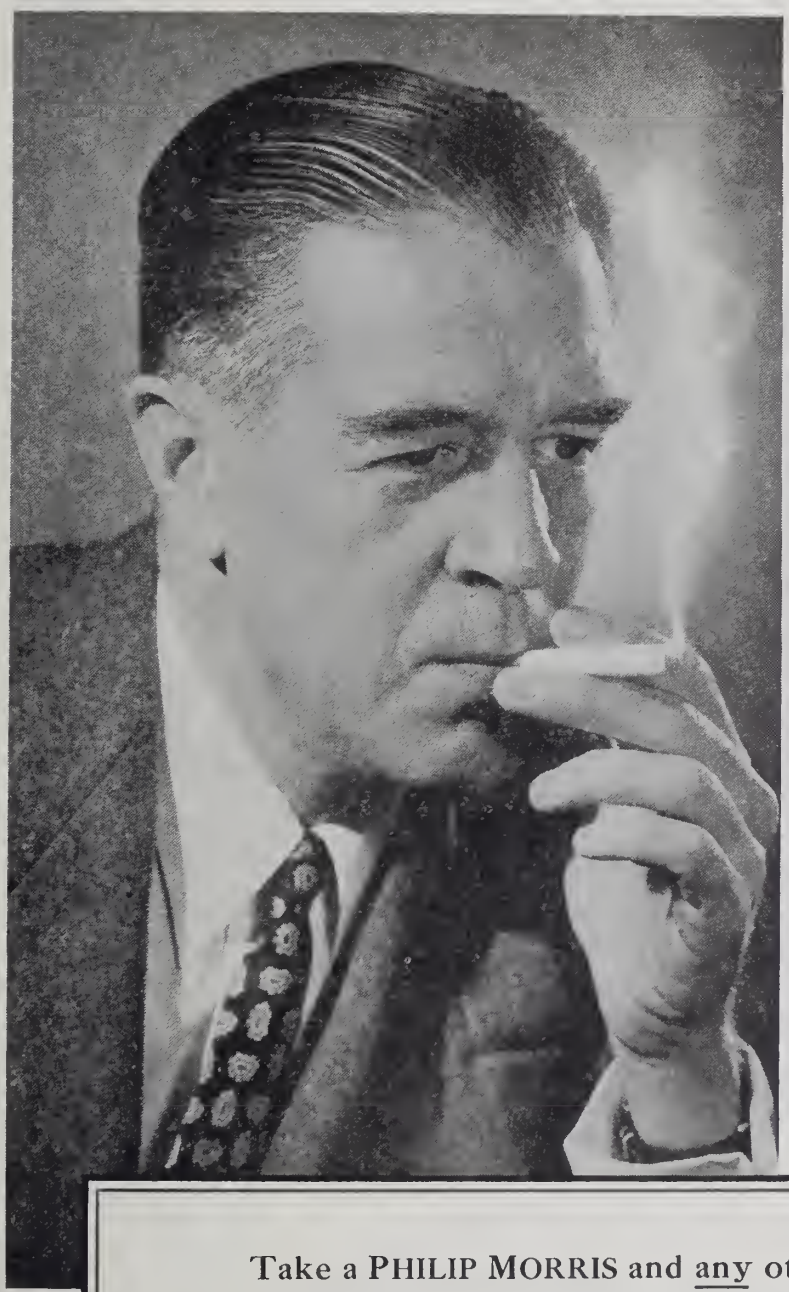
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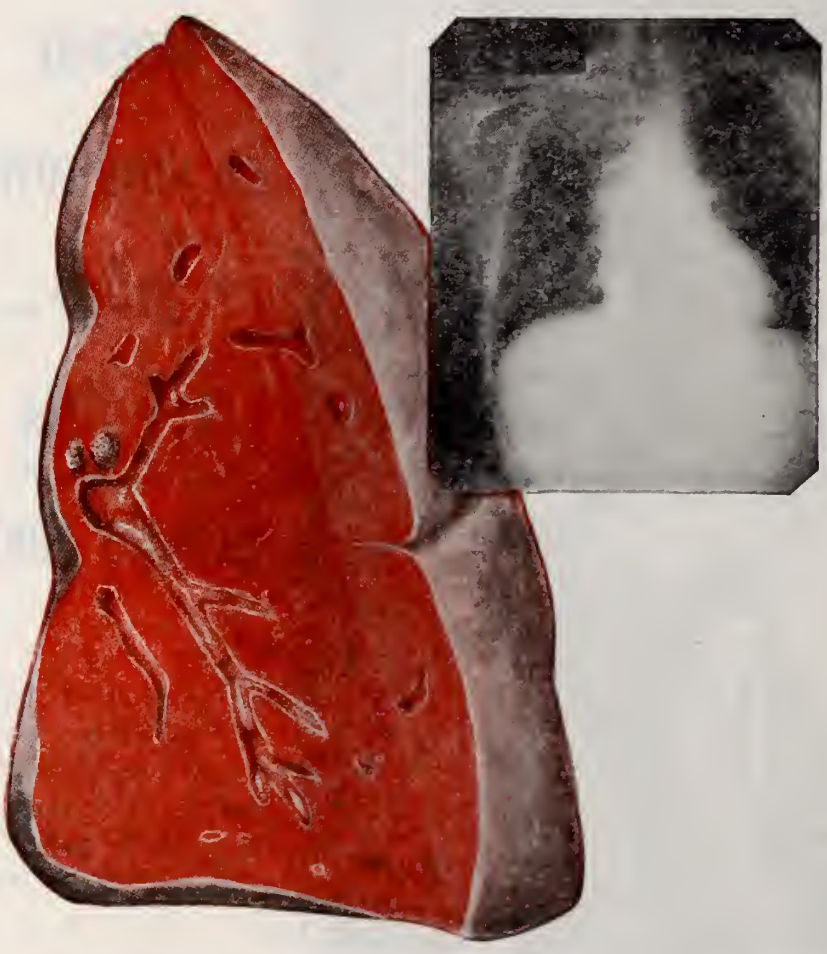
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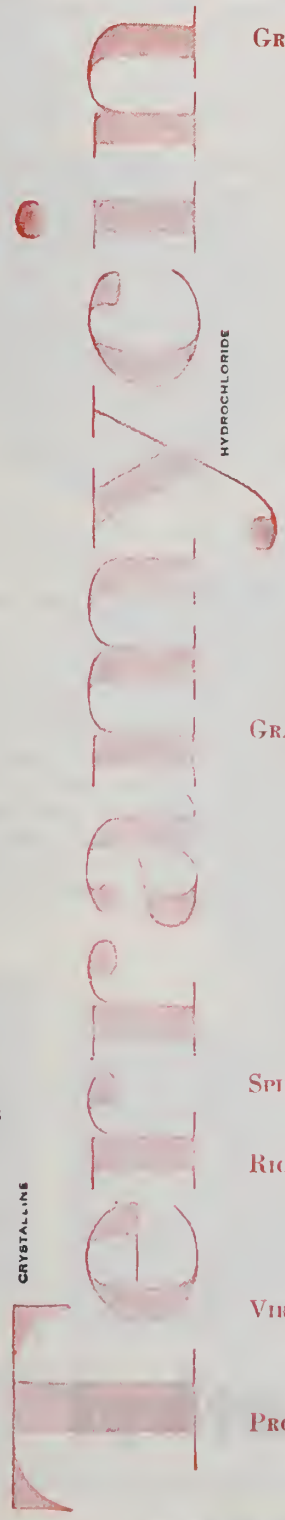
in primary atypical pneumonia:

"It is our clinical impression, supported by the presented data, that terramycin is the drug of choice in the treatment of atypical pneumonia in infants and children."

Graves, F. B., and Ball, W. O.: J. Pediat. 39:155 (Aug.) 1951

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Acute follicular tonsillitis
Septic sore throat • Pharyngitis
Acute and chronic otitis media
Acute bronchitis • Laryngotracheitis
Tracheobronchitis • Sinusitis
Chronic bronchiectasis
Pulmonary infections associated with pancreatic insufficiency
Scarlet fever • Urinary tract infections
Acute and subacute purulent conjunctivitis
Acute catarrhal conjunctivitis
Chronic blepharoconjunctivitis not involving the meibomian gland
Abscesses • Cellulitis
Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

GRAM-NEGATIVE BACTERIAL INFECTIONS

Gonorrhea • Brucellosis
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Friedländer's pneumonia
Mixed bacterial pneumonias
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Post-partum endometritis • Granuloma inguinale
Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

SPIROCHETAL INFECTIONS

Syphilis • Yaws • Vincent's infection

RICKETTSIAL INFECTIONS

Epidemic typhus • Murine typhus
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Primary atypical pneumonia (virus pneumonia)
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Amebiasis

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straining at stool:

always distressing . . . frequently dangerous . . . sometimes deadly

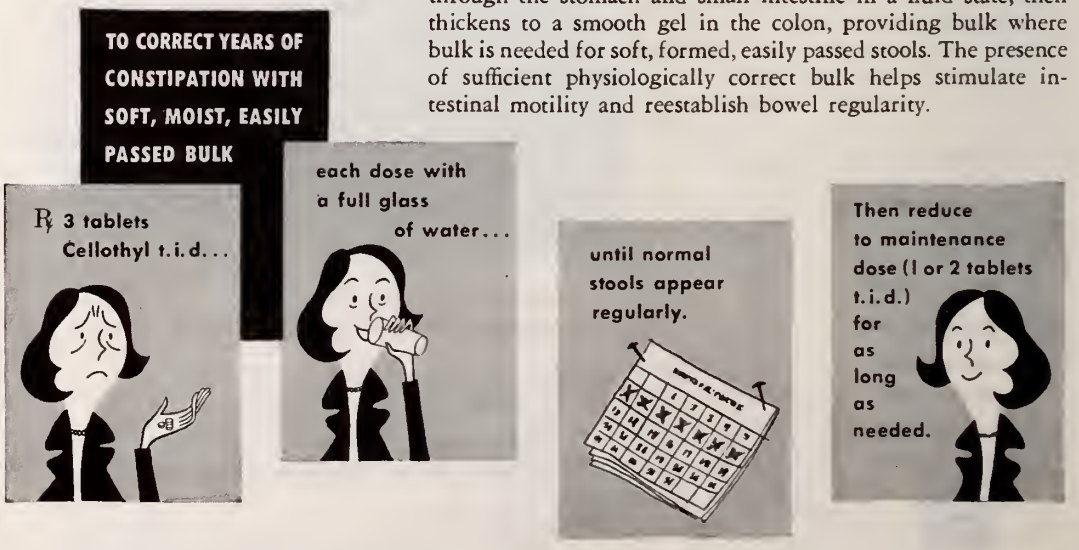
The very states in which straining at stool can be most dangerous are conditions which invite constipation: cardiac dysfunction, hernia, pregnancy, anorectal disease and postsurgical states. In their presence, such almost unavoidable factors as inactivity, dietary restriction, weakness and local trauma lead to constipation due to bowel stasis, bulk deficiency or dyschezia.

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2. *intestinal stasis . . . by encouraging peristaltic action through gentle mechanical stimulation*
3. *dyschezia . . . by assuring soft, moist, easily passed stools.*

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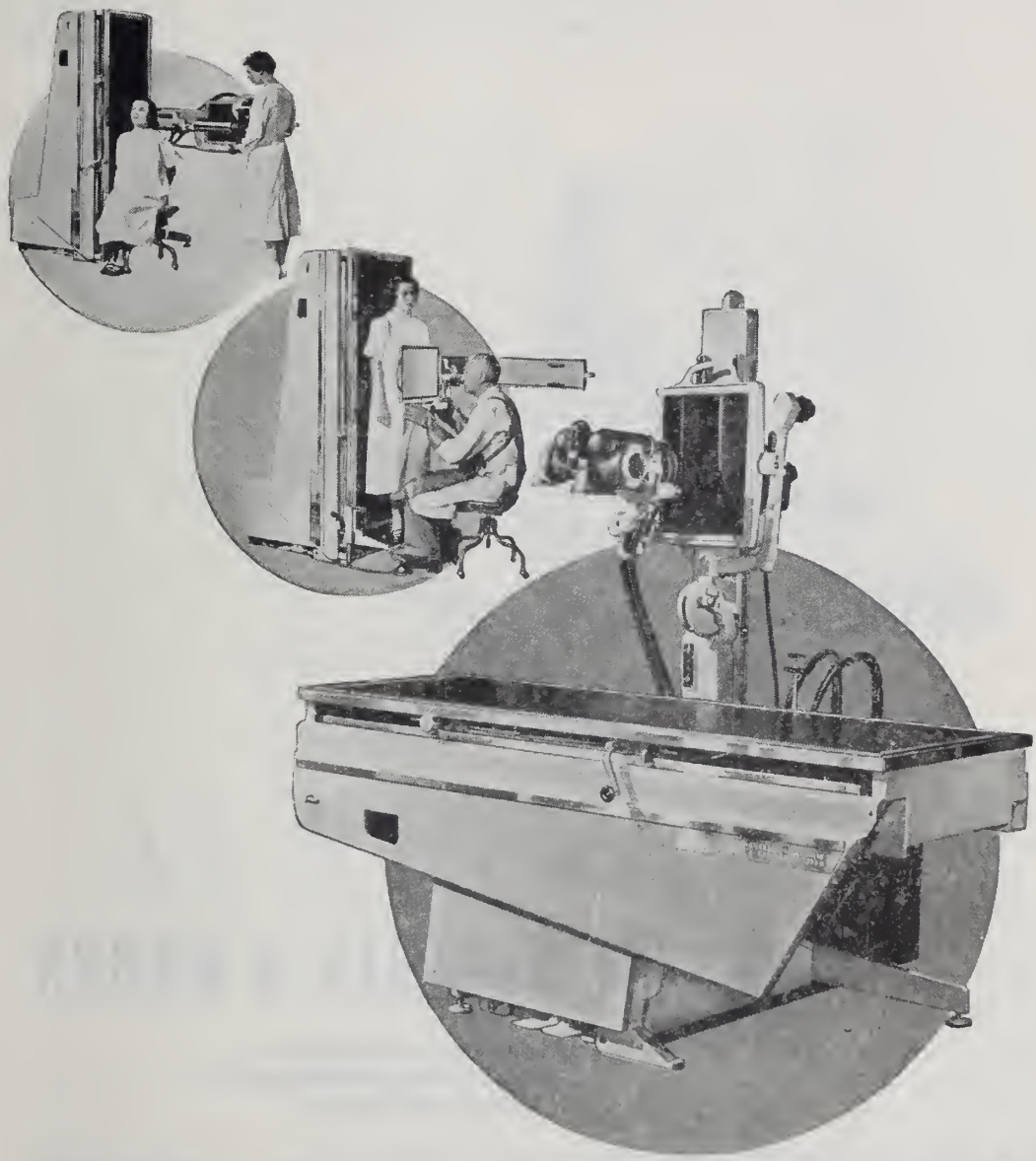


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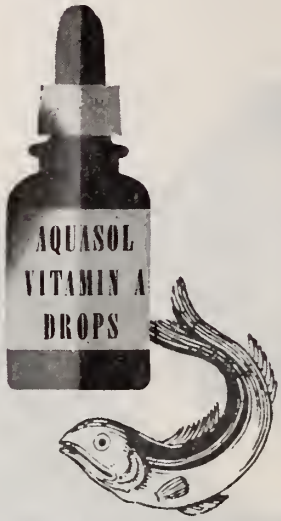
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1. Lewis, J. M., et al.: Jl. Pediatrics 31:496, 1947
2. Kramer, B., et al.: Am. Jl. Dis. Child. 73:543, 1947
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7. Davidson, D. M., et al.: Jl. Invest. Derm. 12:221, 1949
8. Nutrition Reviews 6:248, 1948

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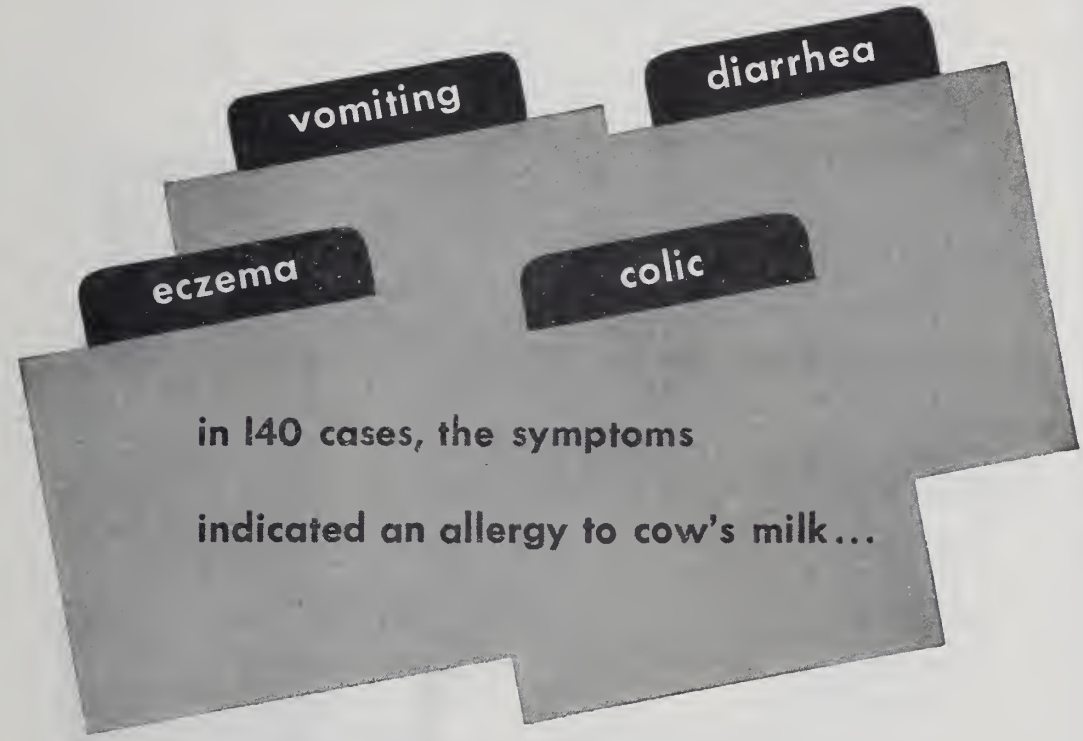
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*Clein, Norman W.: Cow's Milk Allergy in Infants, Ann. Allergy 9:195 (March-April) 1951.

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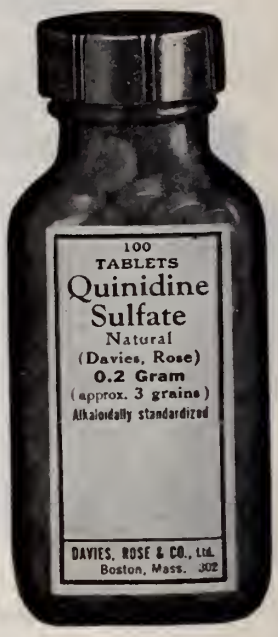
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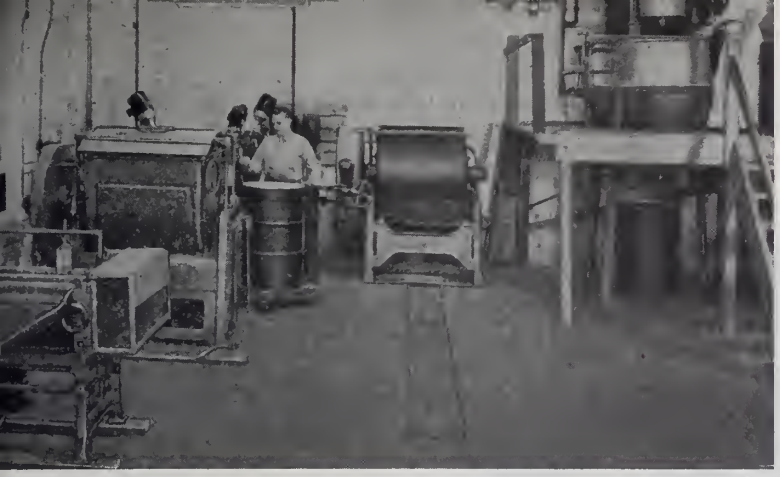
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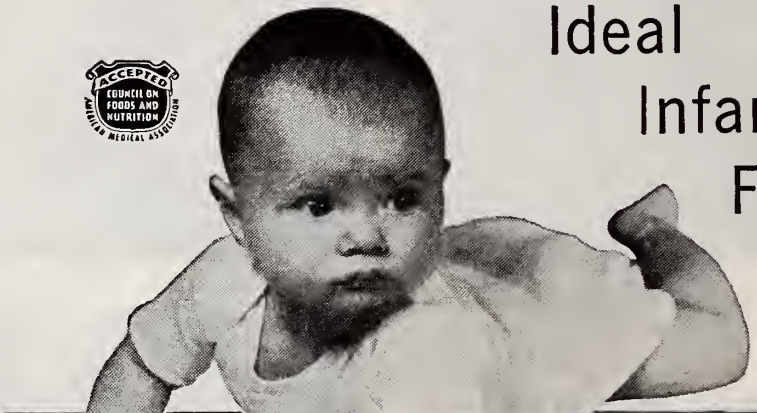
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE 1904

Whole Number of Issues 571

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PRESIDENT'S MESSAGE

Recently the Attorney-General of the State of New Jersey was reported in the daily press as having announced to a meeting of county prosecutors that investigation had revealed that some physicians had been guilty of writing as many as three or four prescriptions daily for narcotics for the use of a single person, charging a fee of $3.00 for each prescription.

On the basis of this information — which was not further clarified or detailed—the Attorney-General is reported to have proposed, with the approval of the assembled prosecutors, that a new law should be framed to control the issuance of all prescriptions for narcotics, by means of the establishment of a state agency through which all such prescriptions would have to be cleared. The projected law would also stipulate that prescriptions for narcotics be given "only for curative and medicinal purposes".

Here we see again how the entire medical profession is summarily and publicly maligned and besmirched by reason of the misdeeds of a guilty few. The implication is that medicine is complacently indifferent to shortcomings within its ranks, and therefore requires discipline and reformation from without.

Nothing could be farther from the fact. The Medical Society of New Jersey, all the component county societies, and the vast majority of individual practitioners throughout the state are ceaselessly and conscientiously vigilant for the preservation of the integrity of the profession and the furtherance of the public good. Consistently we have done all in our power to encourage constructive legislation and to aid law enforcement

agencies in the apprehension of law-breakers of every kind. If there have been those who broke the law and went unpunished—either through the misuse of narcotics or other means—the agencies of law enforcement and not the members of the medical profession have been remiss.

The entire matter demands complete and fullest investigation and disclosure. Fairness to the great army of high-minded and worthy practitioners of medicine demands no less. It is our confident expectation that no taint or dishonor will attach to the general membership of The Medical Society of New Jersey. We shall, with pleasure and energy, do all in our power to bring to justice those guilty of dereliction of any kind in this connection, be they of the ranks of medicine or of the laity. But we shall resist strongly any endeavor to impose upon the entire medical profession of New Jersey ill-considered legal restrictions which at once impugn its honor and jeopardize its freedom and efficiency of action.

Sigurd W. Johnsen, M.D.

JOSEPH G. COLEMAN, M.D., 1875 - 1952

It is customary in this Journal to reserve editorial obituaries for past presidents only. Yet Dr. Coleman so typified the ideal of the physician, that it seems appropriate to salute him and others like him in some special fashion. Not that there are many like him left.

The biographic facts can be swiftly and simply told. Born in Goshen, New York in 1875, he spent most of his life in Sussex County, New Jersey. He was a general practitioner—a family doctor, in the best tradition of that phrase. In a half century of practice he delivered seventeen hundred babies. To hundreds of the adult residents of Sussex County, Joseph Coleman was the only doctor they ever had. Unlike so many of us today, he took his civic responsibilities seriously — but modestly. He didn't make speeches from soap boxes or write indignant letters to the editor. But he made himself a good citizen. He was a member of his borough council (Hamburg, N. J.) for almost a decade. He was a trustee of his church, a member of the Board of Education, a master of his lodge, a commander of his service organization. He helped found the Hardystone National Bank and served as its president. He was on the state council for the Emergency Relief Administration and even had a tour of duty as chief of the local fire department. In the first world war, he was on active service with the medical corps, and during the second he was chief medical examiner of the county draft board. He had several terms as coroner, and at the age of 26, he was already president of his county medical society.

All of this was crammed into the busy life of a rural general practitioner in an area where the roads were often poor, the weather often rugged. But he didn't complain. He didn't ask for a chrome-plated, steam-heated, urban office from which he need never stir when the weather or the going was tough. He served as a member of the Welfare Committee of The Medical Society of New Jersey for ten years and he was a Trustee of our Society at the time of his death.

It is odd that a career like this seems unusual enough to warrant this kind of memorializing. At first glance, it is precisely what one should expect of any doctor. But it describes a *curriculum vitae* that applies to very few of our 5000 members. Most of us feel that we can't find time for those modest kinds of service to the community. It would be nice to be elected to the U. S. Senate, but to serve on a rural board of education, or

be a county coroner, or a trustee of a church, or sit on the borough council of a little American town—these seem too homely to most of us. It is rumored that at times the public is becoming restive about the medical profession. They hurl all sorts of bizarre charges at us—monopolists, or big bill collectors, or self-seeking politicians, or maybe they say we're more interested in diseases than in people. And we feel hurt at these unwarranted grievances, and wonder why so many people seem to love us so much less than they should. Joseph Coleman didn't have that kind of worry. For him, and the few like him, the church is never quite big enough to hold all that come to pay their respects at his passing.

A LITTLE KNOWLEDGE

Until physicians are able to relieve every patient of all his symptoms, a few of the more imaginative laity will seek cures for themselves. Such has been the case for centuries, and is the case at present. Recently there appeared a book by a lawyer, who purports to have found the cure for backaches by a complex system of "self-revolving" the hipbones. Anyone who takes the time to look through this book* will find that this well-printed, privately published volume, is packed with minutiae concerning the supposedly normal function of the hip and sacroiliac joints. The absurdity of such material is obvious upon reading it, but the qualifications of the author are even more so in the light of the present progress of orthopedic surgery.

In contrast to this pseudo-scientific balderdash, stands a recent symposium on backache from the Mayo Clinic.[1] Here in 24 pages is summarized current orthopedic thought on the causes and treatment of backache. Reviewing 2000 cases of backache at the Mayo Clinic seen during 1940, these authors found 22 per cent due to suspected protruded disk, 6.5 per cent due to rheumatoid spondylitis, 2 per cent due to tuberculosis, plus others due to metastatic neoplasms, gynecologic disease, primary cord tumors, et cetera. Such structural lesions can hardly be relieved by self-revolving one's own hip bones! Careful examination of the patient is stressed, and methods of examination outlined in detail. Congenital, degenerative, and infectious lesions are considered, and the prosthetic management of backache described. Here is a scientific approach to the problem of backache by men who have adequate training and experience in their chosen field.

The potential harm that may come of the lay-written backache book is difficult to estimate. It is to be hoped that few persons with serious back disorders will delay getting orthopedic counsel while trying to treat themselves by such maneuvers as self-rotation. However, if only one patient with a spinal cord tumor or tuberculous spondylitis were to become hopelessly crippled by such foolishness, serious damage would have been done. For that patient, a little knowledge would be a very dangerous thing. In the long run, the success or failure of such self-treatment books, devices, and medication will depend on how effectively the treating physician guides his patient with backache into the proper orthopedic hands.

* See review, page 122 this issue.

1. Ghormley, R. K., *et al.*: Symposium on Backache in Medical Practice, Proceedings of the Staff Meetings of the Mayo Clinic, 26:457 (Dec. 5, 1951).

THE CANCER CRUSADE

Next month's campaign for the American Cancer Society will be keyed to the theme that individual monetary contributions will materially assist in the conquest of cancer. The doctor at first is inclined to reject this thesis. Because of the importance of the cause and the sincerity of the sponsors, he is unlikely to voice any objection. But in his own thinking, there will be skepticism. He will argue that you cannot buy a cure for a cancer; that the Cancer Society, like most other voluntary health organizations, spends little of its money on paying for medical care; that the public is unintentionally misled into thinking that it does; and that there is something derogatory to the physician in the implication that an impoverished cancer sufferer will be neglected if he doesn't somehow find the money to pay for his care. For all these reasons, he does not support this and other voluntary health campaigns with as much enthusiasm as the sponsors like to see.

It seems only proper to point out that the American Cancer Society operates in a scientifically correct, promotionally honest and economically sound basis. To be sure, it does not spend much of its budget on the direct care of cancer patients. But it does do a necessary job in educating the public about the nature and curability of cancer and about the need for seeking swift personal medical advice. And it does promote research which, after all, is the prime hope for finding a cure. When the Society in its advertising says "it seeks to save lives", the practitioner tends to rebel, because the Society has failed to make clear that there *is* a direct relationship between the contributor's dollar and the saving of lives. But there is. A single incipient cancer patient, alerted to early medical attention by these advertisements, has had his life saved. And there are thousands such cases. The doctor wonders about the slogan: "Cancer strikes One in Five: Your Dollars will Strike Back." Yet it is a sound slogan, for those dollars keep going the twin facilities of research and public education—activities which do and will pay off in lives saved.

Nor is the provision of direct medical facilities by the Society to be ignored. While this is not the major item in their budget, it is certainly an important one. And other direct services: transportation to hospitals and clinics, dressings, comfort articles et cetera, are provided. Readers of this JOURNAL are aware of numerous technical aides furnished by the New Jersey Division of the Society as reflected in the seven previously published original articles on the Cancer Program in New Jersey.

Almost a thousand investigators are today receiving the Society's grants in aid for cancer research. If only one of them finds a valuable therapeutic technic, the Society will have more than justified all it has done and all it has ever asked for. To be sure, there are a dozen other voluntary health organizations each clamoring for the public's contributions. But few diseases are as widespread, as deadly, and as poorly supported in terms of nationwide financial grants as cancer. It would seem as if every conscientious physician would want his office to be a focal point for telling his patients about this Society, the spearhead of one of the noblest crusades of our time.

ORIGINAL ARTICLES

THE GENERAL PRACTITIONER TREATS THE UNCOMPLICATED DIABETIC*

Everett O. Bauman, M.D., Newark, N. J.

Not only the general practitioner but even some internists throw up their hands at the very mention of the word "diabetes". This is not surprising for two reasons. One is the comparative newness and changes in the detailed therapeutic approach to the subject. Second, corollary to the first, is the lack of emphasis given the subject in most medical schools up to the last few years. This deficit in instruction is now being made up, but all except a few of the older graduates are in a state of uncertainty about diabetic therapy and even diagnosis. With the increased incidence of diabetes in the general population, its recognition should be as much a part of the common knowledge of the general practitioner as the recognition of lobar pneumonia was in the past. The diabetic specialist too often runs into the story of the patient in whom a small amount of reducing substance in the urine has been benefitted by no other diagnostic procedure than the restriction of the carbohydrates of the diet. The classical symptoms of polyuria, polydypsia and weight loss are seldom misconstrued, but a surprising number of patients are treated for a nonexistent diabetes.

DIAGNOSIS

Classical symptoms plus large amounts of reducing substance in the urine (1 per cent or more) and a fasting blood sugar of over 130 require no other diagnostic procedure. In the absence of these criteria, other diagnostic procedures are in order. When in doubt, particularly if the fasting blood sugar is less than 125, a short cut procedure on the usual glucose tolerance test may be used. This consists of giving the patient 100 Grams of glucose in lemon flavored water or 27 ounces of orange juice on an empty stomach. This amount of orange juice contains approximately 100 grams of monosaccharide carbohydrate. As with other forms of the glucose tolerance test, the patient should have been on a moderate to high carbohydrate diet for about a week before the test. A urine should be collected one hour after the ingestion of the carbohydrate and a blood glucose and urine sample taken two hours after the ingestion. The appearance of a blood glucose of 130 or more at this time is almost certain to mean an impaired carbohydrate tolerance and probably diabetes mellitus. By obtaining a urine sugar determination at the same time, a low threshold to glucose may be detected if spill occurs with blood glucose below 160. A pseudodiabetic curve can occur if a high carbohydrate diet is not eaten for several days before the test. If intracranial conditions, thyroid disease, adrenal diseases, diffuse pancreatic or liver disease are ruled out, it then may be assumed that the patient has a true diabetes mellitus. A glucose tolerance test might be dangerous or at least might aggravate an existing diabetes if it is done in spite of a known abnormal fasting blood sugar. The test should be restricted to cases in which there are equivocal symptoms, small amounts of reducing substances in the urine and a normal fasting blood sugar.

TREATMENT WITH DIET

Mild cases of diabetes should not be allowed to go without dietary instruction, so that the case may have a chance to *remain* mild. A mild case may be said to exist when a glucose tolerance test is necessary to bring out its existence or even those cases where postcibal glycosuria exists without glucose in the fasting urine specimen. Sevringhaus has even gone so far as to say that patients who initially show no acetone but only glycosuria probably can

* Presented at a Staff Meeting of the Dover General Hospital at Dover, N. J., April 10, 1951.

be managed without insulin. These criteria of mildness are for therapeutic approach only and not for final evaluation of the severity of the case.

Diet is the definitive and specific therapy in mild cases but by no means the whole therapy. It must be clearly explained to the patient that, up to now, we know only how to treat diabetes and not how to cure it. Therefore, it must be approached as a life long learning. The doctor, preferably personally, should teach the patient to understand the basic principles of the diabetic diet. The oversimplified delineation of calories of protein, fat and carbohydrate as such are often confusing, much as the words in a new language. These and other practical points must be taken into consideration or the regime will fail miserably because of lack of execution. On considering a diet for a *specific patient,* working hours, food preferences, allergies, as well as the facilities available for eating and preparing food must be taken into account. This important environmental history must be appreciated along with a thorough understanding of the patient's previous and present medical and mental deficiencies before a proper and workable dietary regime can be outlined to the patient.

There are many ways in which these purposes can be accomplished. Everything from high fat diets to free diets have been recommended. Theoretical considerations for each method are not within the province of this paper. The method described below is based on the current consensus that a moderate to high carbohydrate diet is closer to the usual eating habits of the average American, better for the prevention of the premature arteriosclerotic changes of diabetics, and better for the middle ground method of neither overstraining the damaged carbohydrate mechanism or allowing it to go further into disuse atrophy.

The dietary regime here presented may be used for the mild cases as defined above. It is meant for anyone who can understand little more than the four words "milk", "bread", "cereal" and "fruit". The basic points of the method were originally worked out by Theodor Teimer, and have been used for many years in the Newark City Hospital Metabolic Services, as well as by their members in their individual practices.[1] It has been applicable to everyone from a child to a truck driver. The foods mentioned have been selected as the A, B, C's of the diet because in various combinations they constitute the main carbohydrate bearing foods of the average diet and are easily available and prepared under a variety of circumstances. Most people enjoy these foods or their carbohydrate bearing substitutes. Furthermore, these foods are consistent with such complicating conditions as the diet required in various gastro-intestinal disturbances. The distribution of these carbohydrates may be modified for patients who desire smaller breakfasts, as an example of fitting individual preferences. But the total amount constitutes a basic test diet and should be used at first, with certain exceptions for obese diabetics. The "essential foods" of Table 1 contain 203 Grams of carbohydrate, 30 Grams of fat, 55 Grams of protein, and 1300 calories. For two days the patient may be instructed to take nothing but these foods, for the purpose of cementing the fundamental nature of them in the patient's mind. If he objects on the grounds that he will not be satisfied with this meagre diet, the figure of 1300 calories may be mentioned just for morale purposes, and the promise made that this will be just for the start. Actually no more carbohydrates are added to the diet unless the patient exhibits an increased tolerance as well as increased caloric requirement. Gluten bread is not included among those allowed, because of its low carbohydrate content. The patients may be further encouraged at the onset by telling them that a *diabetic may eat anything,* and then with a meaningful pause in the voice, add "if they know how much". This regime is based on the idea that only the *essential* foods or their *substitutes,* as outlined in Table 1, enter into the *significant dynamics of the carbohydrate metabolism* of the body.

The negligible carbohydrate, or *free foods* of Table 1, may be added on the third day. The protein of meat, cheese and eggs is theoretically 56 per cent convertible to carbo-

1. Weiss, Selma: Journal of The Medical Society of New Jersey, 45:554 (1948).

TABLE I

ALWAYS BRING THIS DIET TO THE OFFICE WITH YOU

Patient's Name **Date:**

ESSENTIAL OR "MUST" FOODS to be taken at **EXACT** times and **EXACT** amounts:

INSULIN:

	Breakfast ← 4 hrs. →	Dinner ← 5 hrs. →	Supper	Bedtime
MILK	8 oz	8 oz.	8 oz	8 oz.
BREAD White Rye Whole wheat regular sized slices	2 slices (60 grams)	2 slices	2 slices	
CEREAL (dry wt.)	3 level tbs. oatmeal (30 gms)			
JUICE (unsweetened) Orange Pineapple Grapefruit	4 oz.	4 oz.	4 oz.	

FREE FOODS may be taken at any time in any amounts with or between meals:

Meat, Poultry and Fish
Eggs
Cheeses
Butter
Cream (sour or sweet)
Vegetables (**except** potato, corn, lima beans or peas) (fresh, frozen or canned without sugar)
Tomato Juice
Coffee
Tea
Carbonated Water
Salt
Other Seasoning
Whiskeys
Dry Wines
Gin
Clear soups (plain or with meat and vegetables)
Lemon juice
Nuts (**except** chestnuts)
Olives
Saccharin or Sucaryl

SUBSTITUTES FOR "MUST" FOODS:

Milk 8 oz. equals Beer 8 oz.
equals Buttermilk 8 oz.

Bread 1 slice (30 gms.) equals Plain cake—2/3 slice
equals Potato—size of a large egg (cooked)
equals Oatmeal—2 level tbs. (dry)
equals Pancake flour—1½ level tbs. (dry)
equals Noodles or Spaghetti—½ cup (cooked)
equals Corn flakes, 7/8 cup
equals Rice Crispies, 5/8 cup

Fruit Juice, 4 oz. (½ water glass) equals
1 large orange
1 medium pear
½ medium cantaloup
½ medium grapefruit
1 medium banana
1½ cups strawberries
1 medium apple
2 medium peaches
2 small plums
1 medium handful of grapes or cherries
These may be fresh, frozen or water packed unsweetened

Fruit Juice 4 oz. plus Milk 8 oz. equals Ice Cream, 2 medium scoops

hydrate, but by practical experience, tremendous portions of these foods eaten in the presence of the carbohydrate available in the *essential* foods do not seem to influence the blood or urine sugar at all. Therefore, these predominantly protein foods are left to the limits of the natural self demand of the appetite of the patient and the limits of the optimum weight of the patient. Vegetables have been more or less generally divided into 5, 10, 15 and 20 per cent groups, or 3, 6, 9, 12 per cent according to the dietary list consulted. Actually, all except potatoes, corn, lima beans and fresh peas (among the common vegetables) are predominantly cellulose or of such slowly absorbable carbohydrate content that their unlimited consumption does not influence glycosuria in most patients. The capacity of the average human stomach is a limiting factor itself, especially when the consumption of the essential four carbohydrate foods is given priority. Other free or negligible carbohydrate foods are indicated in Table 1.

Even the free foods are limited, however, but for other reasons in specific cases. For example, high fat foods are limited when the patient is fat to begin with or has a tendency to gain easily. An average weight for the height, age and sex is the ideal weight for the diabetic, since obesity tends further to diminish carbohydrate tolerance. The limiting or elimination of such foods as fat meats, eggs, cheese, butter or cream are generally directed to the patient under such circumstances. In obese, mild diabetics the elimination of obesity is usually enough to insure a practically normal carbohydrate tolerance. In obese cases even the four essentials may be cut to eliminate all but skimmed milk, and part of the bread may be substituted by extra portions of fruit between meals. The free foods allowed would be restricted to the leanest meat, skimmed milk cheeses and the free vegetables plus coffee, tea, tomato juice and clear fat free soups. In cases of extreme and resistant obesity, diets as low as 600 to 800 calories may necessitate cutting down the amount of the "must" foods also.

The basic carbohydrate foods plus the free foods provide a nice variety in themselves. For simplicity, dietary instruction may temporarily end there. The substitute appreciable carbohydrate foods may be introduced in one or two days. A list of the equivalents may be given to the intelligent patient to study and use; or one food at a time may be added as a substitute for the essentials as requested by the patient. Two principles must be kept in mind on all substitutions of carbohydrate foods. Fruits should be substituted for fruit juices because they are made up of carbohydrates of similar digestion and absorption speeds, namely, monosaccharides. Milk should be substituted for such carbohydrates as those found in beer and buttermilk for the same reason. Similarly, bread should be substituted for foods containing similar polysaccharide carbohydrates as indicated in Table 1. Foods of similar carbohydrate speeds should be substitutable. Secondly, substitute foods must be given at the same time the essentials are allowed and not at odd times. There is a rule about foods in general, as well as substitutes. If a patient is not content with a definite allowance of a certain food (such as ice cream) then that food should be completely interdicted (much as an habitual type alcoholic must have all alcoholic beverages removed). Such prohibitions are practically never necessary, because a person, suddenly told that he may have a food anticipated as forbidden, will usually lose his excessive craving for it.

If after a week to ten days of this type diet, the patient shows a tendency to decrease carbohydrate spill after some meals but not after others, in some consistent pattern, then the mono- and/or disaccharide carbohydrates at the offending meals may be lowered or eliminated (milk and fruit juices), because they are the hardest for the slowed carbohydrate mechanism to utilize before they are excreted. They may be slowly reintroduced later at a time of better carbohydrate tolerance. Patients may sometimes tolerate a substitution of the slow carbohydrate bread, as an additional slice, where the monosaccharide may be too rapidly excreted.

CRITERIA OF CONTROL

The best way to follow the progress of a patient is by fractional *quantitative* urines taken daily to correspond with the meal intervals and the night fasting period. For office use this procedure is impractical and, therefore, the next best procedure is utilized. The peak spill is estimated after meals by obtaining specimens two hours postcibally and the urine on rising is tested with the other three, daily, at first. Only in this way can a complete pattern for the day be seen. The qualitative Benedict method is the one of choice and should be followed exactly. Even when the patient is well regulated, biweekly, weekly, or semiweekly urines should be tested in the number and manner described, but daily urines are probably no longer necessary. A single negative specimen before breakfast, even daily, merely indicates no glycosuria after an eight to twelve hour fast. This is not a test of carbohydrate *utilization. Adequate carbohydrate utilization is the final criterion of control.* Ideally, at first it would seem desirable to establish a baseline for the patients and make the urine as sugar free as possible. At this level all carbohydrate fed would be metabolized. (Theoretically, fluctuations in the blood sugar *below* the urinary spill level might impose an added strain on the carbohydrate metabolism. Practically, this is difficult, if not impossible to demonstrate. Therefore, the maintenance of a given blood glucose maximum, *per se,* is not necessary.) Once a baseline has been established, either with or without the use of insulin, showing complete carbohydrate utilization, if the patient occasionally spills an appreciable amount into the urine, one may return to the baseline. This may be done by correcting the factor which caused the deviation whether it be an error in diet, or even an intercurrent infection. Urinary glucose spill is allowable provided the total carbohydrate utilized is at least 150 to 200 Grams. If an intake of 200 Grams is present and the patient eliminates even as much as 10 to 20 Grams, the balance is still 180 Grams. Quantitative estimates of 24 hour urine specimens may be necessary to determine this, and, of course, should be reported in *Grams of glucose* in the total specimen and not as percentage spill. The constant metabolism of 150 to 200 Grams of carbohydrate will almost always prevent acidosis and probably prevent the premature vascular degenerative processes which supposedly go with prolonged underutilization of carbohydrates. Any glycosuria in a quantity enough to cause polyuria and subsequent weight loss must always be avoided.

USE OF INSULIN

If these objectives are not accomplished without the use of insulin, then insulin must be called on to establish the carbohydrate balance required. Indications for the use of insulin are: (1) failure to establish adequate carbohydrate balance with diet alone (this may occur because the patient's caloric and carbohydrate requirements are higher than the 200 Grams outlined in the basic diet); (2) urgent, intractible symptoms of polyuria, polydypsia and weakness which would respond only to a very much smaller carbohydrate allowance than outlined above. Many patients would rather take insulin than to have their diet cut down even for a period of a few weeks. Eventually, many of these patients come off insulin; (3) patients showing clinical or laboratory evidence of ketosis; (4) patients showing severe infections along with diabetes mellitus either with or without accompanying ketosis are usually safer with insulin.

There are as many ways of insulin therapy as there are diet methods, and they all eventually lead to some form of control. Certain objectives should be kept in mind in any insulin regime. First, control should be obtained in as short a time as possible. Second, during the control period as well as later, insulin reactions should be avoided. Reactions are an unpleasant and sometimes an alarming incident, enough to discourage the novice from pursuing the proper administation of the insulin. Third, the smallest amount of insulin necessary in the least number of injections at the most convenient time of day is best for any practical insulin regime. With the various speed insulins now available (if one remembers the timing of each) this may be readily accomplished.

Patients may be told in the beginning that

one is no more able to predict their individual final controlling dose than one is able to predict the amount of gasoline that it will take to drive a car to the top of a hill. No more predictable is the final maintenance dose of insulin. One can usually say, however, that the controlling dose will probably be somewhat greater at first than the later maintenance dose.

The simplicity of insulin administration and injection must be painstakingly taught in a step by step fashion with a greater care for all the little details of sterility and proper distribution of the injection sites in convenient and evenly divided locations. Some doctors even demonstrate the injection technic on themselves or use automatic injectors in order to encourage the more timid patients.

The method of dosage to be described is based on control with regular insulin first. (Table 2). Some small dose of regular insulin regardless of the urine spill of glucose, provided there is no clinical ketosis, is given once before breakfast. A safe dose is ten units given 20 to 30 minutes before breakfast. Each day this dose is raised 5 or 10 units until the *after lunch urine* specimen shows a green or less on the Benedict's test. Regular insulin often does not have its maximum effect at first on the breakfast even though given before that meal and, therefore, the two hour after lunch is used as the criterion for regu-

TABLE 2

OUTLINE OF A PLAN OF INSULIN DOSAGE

R—Unmodified Insulin P—Protamin zinc insulin NPH—NPH insulin

	Before Breakfast	*Before Lunch*	*Before Supper*	*Bedtime*
I	R Starting with 10 units	O	O	O
II	R+5 units, increased q 1 - 2 days until A. L. urine is green	O	R starting with 10 units and add 5 units q 1 - 2 days until A.S. urine is green	O
III	R	O	R	P starting with 10 units and add 5 units q 2 - 3 days until B.B. urine is green or blue
IV	R Example: 25 units	(R rarely used here; only when B.B. insulin fails to affect the A.L. urine) O	R 25 units	P 25 units
V	R P=Before supper R plus bedtime P given separately before breakfast only Example: 25 units R 50 units P	O	O	O
VI	R=Before breakfast R plus ½ P units P=½ P units *combined* in *one* injection before breakfast only Example: 50 units R(25 + 25) 25 units P combined	O	O	O
VII	NPH used only if the combination calls for approximately 2 parts R to 1 part P Example: 75 units NPH			

lating the before breakfast dose. If one depends on the *after breakfast* specimen to show blue or green reactions before stopping the insulin increase before breakfast, reactions are more likely to occur. If the two hour after-supper specimen is not affected by the general improvement of metabolism within two or three days, a small dose of regular insulin may be given before supper or a similar dose of protamin zinc insulin before breakfast, in a separate dose from the already started dose of regular given at that time. For simplicity, it is better to continue with the regular before supper in the more difficult cases. The dose of regular before supper is increased gradually in smaller steps than before breakfast and more cautiously (5 units at a time) until the two hour after-supper specimen shows blue or green. In most cases this is the only administration of insulin necessary, but occasionally a stubborn spill persists before breakfast. Either increase of the before-supper regular or the before-breakfast protamine may produce reactions during the night, in spite of bedtime feedings. Therefore, the solution of the before breakfast spill is often found in progressive doses of protamin zinc insulin given at bedtime, increased slowly in 5 or 10 unit steps until the before breakfast specimen becomes negative.

Once green (or 0.25 per cent) spill has been reached two hours after lunch and supper and before breakfast, the insulin dose is ready for the final adjustment. Any regular insulin given before supper plus whatever protamine is necessary at bedtime is combined into one dose of protamin zinc insulin given before breakfast, separately but in conjunction with the dose of regular insulin necessary before breakfast. After a pause of about five days at this step to be sure the same level of control is maintained, combination of the two insulins in one injection before breakfast may be accomplished in the following manner. Half the number of the protamin zinc insulin units is converted to regular insulin and added to the regular insulin units already required. The remainder of the protamin zinc insulin units are given as protamin zinc insulin. These two doses, of the corrected regular insulin unitage plus half the original unitage requirement of the protamin zinc insulin, are then combined in a single injection before breakfast. This method is based on the excess protamine put in the protamin zinc insulin complex allowing for combination with at least again as much regular insulin. If the final dosage is approximately in the proportion of two units of regular insulin to one unit of protamin zinc insulin, a dose of NPH insulin equal to a total of the two may be substituted for the combination, because NPH is essentially a modified two to one combination. Table 2 will show examples of this method.

This seems at first to be a formidable procedure, but if carefully followed step by step this plan will usually control the most resistant cases by simple office visit instruction and within an outside limit of three to four weeks in the most difficult cases. Most patients who need insulin are controlled with the first one or two steps in a period of no more than a week to ten days. It is only in the more difficult cases that all the steps of the routine must be followed through. It must be remembered that once the controlling dose is reached, this may be far too much to continue. Therefore, over the next few weeks the dose may be gradually diminished to the point where the patient is allowed the safety margin of a few green or greenish yellow specimens after meals, 0.25 to 0.5 per cent respectively.

The amount of exercise, especially in manual laborers and children, may considerably modify the insulin requirements and must always be kept in mind. For this reason there is an advantage in controlling diabetics rather by daily office visits than by placing them in the artificial rest atmosphere of a hospital. Office control procedures give neither a false exercise pattern nor restrict the normal activity of the patient. Immediate ambulation and office visits are good mental hygiene in addition. Even though a regular exercise pattern may be known, activity spurts may call for high carbohydrate food supplements, whether it be for a housewife on a spring cleaning day or a child about to go for a vigorous afternoon swim. Such activities, whenever possible, should be anticipated by extra carbohydrate food intake rather than to wait for signs of insulin reaction.

BLOOD GLUCOSE DETERMINATIONS

Little has been said about blood glucose levels. For the records, a determination as an added (but relatively unimportant) guide should be made at the beginning of treatment, about a month after treatment has started and again occasionally at three to four month intervals. The routine interval checkups are principally for re-appraising the threshold level of glucose and to discover actual or potential hypoglycemic levels. Urinary glucose spill ordinarily stops at a blood glucose of about 170 milligrams per cent, and below this point reaction tendencies may be judged only by blood glucose levels. For comparative readings probably the only time at which most factors that influence the resultant glucose level may be comparable is before the morning insulin. Determinations may be made at other times for other reasons. In many cases, blood glucose of 200 or over without urinary glucose-spill may persist for years without any discoverable deleterious effect on the patient; thus, a high blood glucose by itself may be of no significance. Fluctuations below the spill level probably have little or no clinical significance except as they approach a hypoglycemic level. *Habitually inadequate carbohydrate utilization* almost always manifests itself by clinical changes, eventually increased severity of the diabetes and more frequent and earlier vascular degenerative changes. Prominent authorities[2] have taken issue with this saying that vascular degenerative changes occur at a fairly definite time regardless of this or any other type of control. From observations on diabetics of ten to thirty years' standing, I am prone to be less pessimistic. There is also evidence in the literature for this viewpoint.

CONCLUSION

With a few basic principles in mind the average general practitioner can control most uncomplicated diabetics without hospitalization. The basic carbohydrate elements of the diet are used as the foundation and garnished and varied with the low carbohydrate and substitute foods. The time of action of the various insulins is kept carefully in mind and the doses placed in relation to the meals so as to cover the carbohydrate foods, avoiding reactions. Finally the patient is taught personally by the physician how to take care of himself by injecting his insulin and testing his urines.

862 South 13th Street

2. Dolger, Henry: Bulletin of the New York Academy of Medicine, 22:482 (1946).

GRADUATE COURSE IN ALLERGY

On April 4 to 6, 1952, at Pittsburgh, The American College of Allergists will offer a graduate course in allergy. The College has called in 60 well known authorities in the field to give addresses, clinical talks and demonstrations. The program has been designed for physicians in other fields of practice, especially those in general practice, so that they may learn to recognize and manage the allergic component in the complaints of their patients. For further information and a copy of the program, write to The American College of Allergists, LaSalle Medical Building, Minneapolis 2, Minnesota.

After the conclusion of the course the American College of Allergists will hold its annual meeting in Pittsburgh.

CANCER CYTOLOGY SEMINAR

The Cytology Center of the Dade County Cancer Institute announces a one-week seminar for physicians at the Institute from April 21 to 25.

The seminar will include a conference on *Carcinoma In-Situ*.

Instruction will be under the supervision of Dr. J. Ernest Ayre, Director of the Institute and its research staff. More than twenty outstanding local and visiting physicians and scientists will compose the faculty.

The course will include lectures, demonstrations and symposia covering the various branches of medicine as related to cancer, including clinical, cytologic, surgical and histopathologic fields.

Physicians may write for details to the Dade County Cancer Institute at 1155 North West 14 Street, Miami, Florida.

Applications for registration, limited to 35 physicians, will be accepted through April 19.

FATE OF CASEIN HYDROLYSATE AMINO ACIDS

ADMINISTERED INTRAVENOUSLY TO HUMAN SUBJECTS*

R. N. CAGAN, M.D., Trenton, N. J.,
R. L. KLEIN, B.S., and LEO LOEWE, M.D., Brooklyn, N. Y.

Casein hydrolysate is frequently given intravenously to supplement the feeding of hospitalized patients. If a considerable portion of the infused free amino acids contained in the hydrolysate were excreted in the urine, the therapeutic value of such treatment could be questioned. While there is some evidence[1] suggesting that only a minimal amount of these free amino acids are excreted[2] further data obtained from hospitalized patients without metabolic disease is desirable.

Furthermore, it was thought that some pattern for the rate of disappearance from the plasma of these amino acids as well as information concerning the rate and extent of their catabolism could be determined.

Procedure. Fourteen hospitalized patients without detectable renal or hepatic disease were confined to bed and were not permitted food for 15 hours prior to the experiment. Water was given as desired until one last glass was given 100 minutes before the infusion of casein hydrolysate.

After blood was drawn, 120 milliliters of a 10 per cent casein hydrolysate solution† were administered intravenously during a period of 12 minutes. (The casein hydrolysate was found to contain 825 milligrams of free amino acid nitrogen per hundred milliliters.) Blood samples were taken at the following time intervals after the end of infusion: 5, 15, 30, 55, 85 and in several cases 120 and 240 minutes. Plasma was analyzed for amino acid nitrogen, glucose and urea.

Fasting, 90 and 240 minute urine specimens were collected under controlled time intervals, measured and analyzed for amino acid nitrogen, urea nitrogen and glucose.

Two patients, used as controls, were given 120 milliliters of 0.85 per cent saline and were followed as above.

Plasma and urinary nitrogen were measured by the Sobel technic,[3] plasma and urinary reducing material by the Somogyi procedure,[4] plasma amino acid nitrogen by the method of Russell,[5] and urinary amino acid nitrogen by Cagan's technic.[6]

RESULTS

The controls showed no increase in their plasma free amino acid nitrogen, while those given casein hydrolysate showed a maximum average rise at the 5 minute level of 3.25 milligrams per cent. (See the graph) This elevation gradually decreased to approach the fasting level at the 85 minute interval. The absolute values for fasting plasma amino nitrogen varied from 3.2 to 5.9 milligrams per cent.

The control patients showed no significant increases in plasma urea and at most an increase of 8 milligrams per cent in plasma glucose. This latter increase was found to occur at the 5 minute interval. However, patients given casein hydrolysate showed an increase of 1.5 to 4.5 milligrams per cent (average 2.1) in plasma urea nitrogen occurring at the 85 or 120 minute interval. Their maximum rise in plasma glucose varied between 6 to 22 milligrams per cent (average 15) occurring not only at the 5 minute period but also at the 85 minute interval. This second elevation in plasma glucose at the 85 minute period occurred after an intermediate interval of regression in the glucose level.

The increase in urinary excretion of free amino acid nitrogen in the saline-infused group did not exceed 3 milligrams for the 240 min-

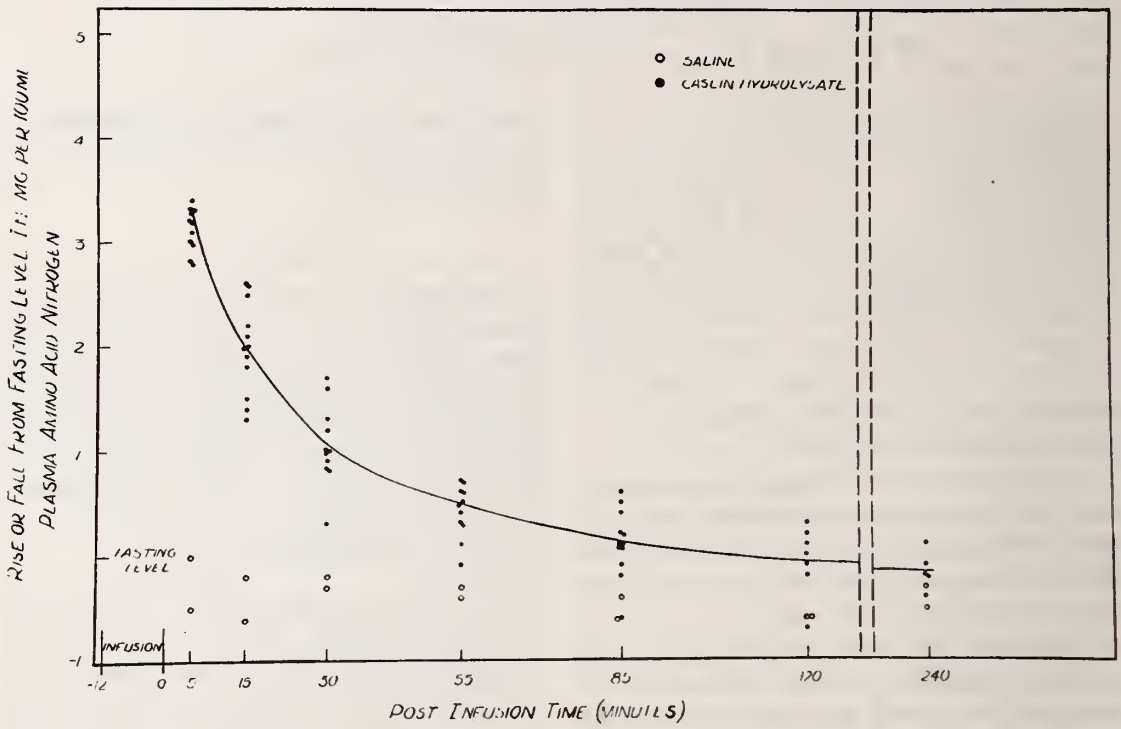
* From the Departments of Chemistry and Medicine, The Jewish Hospital of Brooklyn, New York. This work was aided by a grant from The Jacques Loewe Research Foundation, New York City.

† We should like to thank Dr. Warren M. Cox of Mead Johnson Co. for providing the casein hydrolysate.

1. Lewis, J. H., Taylor, F. H. L., and Davidson, C. S.: Am. J. Med. Sci., 214:656 (1947).
2. Stewart, J. D., and Rourke, G. M.: Proc. Soc. Exp. Biol. and Med., 51:364 (1942).
3. Sobel, A. E., Mayer, A. M., and Gottfried, S. P.: J. Biol. Chem., 156:355 (1944).
4. Somogyi, M.: J. Biol. Chem., 160:69 (1945).
5. Frame, E. G., Russell, J. A., and Wilhelmi, A. E.: J. Biol. Chem., 149:255 (1943).
6. Cagan, R. N., Klein, R. L., and Loewe, L.: Proc. Soc. Exp. Biol. and Med., 78:713 (1952).

GRAPH I

DISAPPEARANCE FROM PLASMA OF AMINO ACID NITROGEN AFTER INFUSION OF 120 ML. OF 10% CASEIN HYDROLYSATE INTO HOSPITALIZED PATIENTS



ute postinfusion period. However, the patients receiving casein hydrolysate excreted an excess of 6 to 20 milligrams of amino acid nitrogen during the same period. (See the table) Absolute values for fasting excretion of amino nitrogen varied between 8 to 19 milligrams per 100 minutes.

The increase in urinary excretion of urea nitrogen and reducing substance after casein hydrolysate infusion may be observed from the table.

COMMENT

The rapid disappearance of amino acids from the blood is in agreement with the work of Friedberg and Greenberg.[7] They found that 80 to 90 per cent of intravenously administered amino acids disappeared from the plasma of rats after 15 minutes. These workers traced the amino acids to the livers, kidneys and muscle tissues of their animals.

Although a 5 minute rise in plasma glucose was noted in the control and experimental group, it was probably an epinephrine response. Newly formed glucose and urea were found in the plasma of the casein hydrolysate group about 70 to 100 minutes after beginning the infusion. There is little doubt, therefore, that some gluconeogenesis and urea formation did take place.

To obtain an approximate idea of the amount of amino acids used for energy purposes, the average amount of urea nitrogen recovered post-infusion from the blood and urine in excess of fasting was calculated as 388 milligrams. This quantity is equal to 14 millimoles of urea produced by 28 millimoles of amino acids. Since 990 milligrams or 70.7 millimoles of free amino acid nitrogen was infused, 39 to 40 per cent of the infused amino acids were catabolized.

Despite the rapidity of administration only 1 to 2 per cent of the infused free amino acids were found in the urine.

CONCLUSION

1. One hundred twenty milliliters of a 10 per cent solution of casein hydrolysate were in-

7. Friedberg, F., and Greenberg, D. M.: J. Biol. Chem., 168:411 (1947).

TABLE

Increase Above Fasting in Urinary Excretion of Free Amino Acid Nitrogen, Urea Nitrogen and Reducing Substance for the 240 Minute Period After Infusion *

Patient	Sex and Age	Diagnosis	Type of Infusion*	Free Amino Acid Nitrogen (990 Mg Infused) Mg	Urea Nitrogen Mg	Reducing Substance (Glucose) Mg
1–5	M 21–36	Dermatophytosis	C	...	...	...
6	M 21	Normal	C	6.0	...	...
7	F 33	Convalescing Subacute Bacterial Endocarditis	C	7.7	...	...
8	M 19	Spinal Osteochondritis	C	7.6	302	132
9	F 43	Rectocele (Pre-Op.)	C	19.7	220	154
10	M 16	Neurasthenia	C	19.5	224	163
11	M 56	Bronchiectasis (Pre-Op.)	C	10.3	391	127
12	M 70	Chronic Bronchial Asthma	C	9.1	471	56
MEAN	..		..	11.4	322	126
13	M 19	Convalescing Infectious Mononucleosis	S	3.0	0.6	0
14	M 53	Convalescing Peptic Ulcer	S	0.0	0.0	0

* C—Patients given 120 ml of 10% casein hydrolysate.
S—Patients given 120 ml of 0.85% saline.

fused at a rate of 10 milliliters per minute into hospitalized patients without detectable renal or hepatic disease. Under these standardized conditions, a pattern for the rapid disappearance from the plasma of amino acids was established.

2. An interval of 70 to 100 minutes elapsed before plasma glucose and urea were seen to rise as a result of the casein hydrolysate infusion.

3. Thirty-nine to 40 per cent of the free amino acids were recovered as urea and 1 to 2 per cent as urinary amino acid. Thus, about 60 per cent of the infused casein hydrolysate amino acids probably was reserved for tissue building.

The authors are indebted to Dr. A. E. Sobel for his guidance and many suggestions in the course of this investi ation.

730 West State Street, Trenton, N. J.
555 Prospect Place, Brooklyn, N. Y.

PHYSICAL MEDICINE SYMPOSIUM

A combined meeting of the Pennsylvania Academy of Physical Medicine and the New Jersey Society of Physical Medicine will be held on Saturday, March 22, from 2:00 p. m. to 5:00 p. m. at Mercer Hospital, Trenton, New Jersey. A symposium on arthritis and peripheral vascular disease will be presented by various specialists.

THE SOCIETY OF SURGEONS OF NEW JERSEY

Announcement has been made of the meeting of the Society of Surgeons of New Jersey to be held at the Sea View Golf Club on May 7, 1952. Members wishing further details should communicate with Dr. McCallion.

THE HYPOPLASTIC UTERUS IN INFERTILITY

Mates Morgenstern, M.D., New Brunswick, N. J.

In genital hypoplasia of the female, a condition which may be caused by pituitary or ovarian insufficiency, or by diminished reactivity to the ovarian hormone, the whole or part of the genital apparatus may be involved. The presence of a hypoplastic uterus alone is a frequent finding. Such a hypoplastic uterus is small, even to the size of a walnut and usually sharply anteflexed. The size alone, however, is not a reliable index of this organ's maturity. It is the proportion of the length of the corpus to the cervix uteri, the "Uterine Index", which is significant.

In childhood, the corpus is much shorter than the cervix, the ratio being 1:2; later on, when maturity develops, the body of the uterus grows much faster than the cervix; the measurements change and finally the ratio becomes 2:1 in the adult female. The uterine index as such is obtained by measuring first the length of the cervix (the distance between the external and internal os), and secondly the length of the whole uterus (the distance between the external os and the fundus).

If 'C' represents the cervical length and 'U' the length of the whole uterus, the quotient

$$\frac{U - C}{C} \times \frac{I}{2} = \text{Uterine Index},$$

gives the proportion of the corpus to the cervix. An index above 0.75 indicates a normal adult uterus; below 0.60, it indicates a hypoplasia of clinical significance.

If the quotient is below 0.25, an infantile uterus is present. The following case described presents an infertility problem mainly due to a hypoplastic uterus.

CASE REPORT

The patient was first seen on May 27, 1949. She complained of pain in her chest of one year's duration, fatigue throughout the whole day and frequent colds. She was 25 years old, had been married for over two years and had tried to become pregnant for the past year.

Her menstrual history was as follows: menarche, age 14. Menses irregular (every 1 to 3 months), lasting 4 to 7 days with a moderate amount of bleeding and occasional pain. The frequency of sexual relationship had been once or twice a week; libido was normal and sexual adjustment was satisfactory. The physical examination revealed a normally developed white female, weighing 105 pounds, and being 5 feet 2 in. tall. The secondary sex-characteristics were normal. Eyes, ears, nose, throat and teeth were normal. Chest examination revealed moderately hypoplastic breasts; areolae and nipples however were normal. Heart and lungs showed no abnormal findings on percussion and auscultation. The blood pressure was 125/90; pulse 84 with regular rhythm.

The gynecologic examination revealed the following: mons pubis normal; no tenderness, rigidity or masses present. The vulva, urethral orifice, Skene's and Bartholin's glands were normal. The vagina was of normal length, the mucous membrane of normal texture and appearance. The uterus was smaller than normal, of hard consistency, moveable and anteflexed. The cervix was long, cone-shaped, and the external os pinpoint. The uterine index was 0.40. The laboratory findings were normal except for a BMR of −30 per cent, a hemoglobin of 70 per cent (12.1 Gm.).

Further evaluation of the patient's infertility was refused for the time being, therefore, only thyroid in form of Proloid[1] gr. ½ three times daily was prescribed, the dosage being gradually increased until a daily intake of 5 grains was reached. Iron was also given. The patient was also instructed to record her morning temperatures and to have intercourse at the upswing of the curve.

Three months later, her basal metabolism had improved to −4 per cent and she was put on a maintenance dose of one grain of Proloid[1] for another six weeks. A blood count was also repeated at the same time and proved to be within normal limits.

On May 27, 1950, the patient decided to continue the evaluation of her infertility. Her husband had a seminal fluid examination which proved to be highly satisfactory as to count, motility, morphology, turbidity and viscosity. Up to this time the regularity of her menstrual intervals had somewhat improved.

A tubal insufflation test proved patency of both tubes. A second uterine index test showed no improvement. Vaginal smears at week-

1. Proloid is Chilcott Laboratories, Inc., tradenamed preparation of thyroid globulin.

ly intervals revealed both proliferative and secretory phases with somewhat decreased cornification. The Sims and Kurzrock-Miller tests showed motile spermatozoa in sufficient numbers.

At this stage, the patient's infertility was attributed to her hypoplastic uterus and treatment was instituted accordingly. On July 25, 1950, immediately after cessation of her last menstrual period (July 20 to July 24), she was given estrogen in the form of theelin in oil, 10,000 I.U. twice weekly for fourteen days followed by progesterone in form of Proluton[2] 10 mg. i.m. bi-weekly until menstruation occurred. This course of treatment was repeated through three menstrual cycles with a striking improvement in her regularity and the appearance of a clear diphasic temperature curve.

Time and intervals of her menses were as follows: August 23 - August 26, inclusive; September 20 - September 22, inclusive; October 21 - October 24, inclusive. Pain and bleeding during these last three menstrual periods were aggravated. During these three months of treatment the patient underwent regular pelvic examinations which revealed a growing uterus, but no measurements were undertaken before October 28, at which time the uterine index had improved to 0.56. At the same time, the patient stated her breasts had somewhat enlarged; physical examination, however could not verify this.

The hormone injections were now discontinued, and the patient advised to continue the temperature chart and have intercourse accordingly. She was also told to douche with a neutral saline* solution prior to intercourse.

On December 26, the patient returned to the office stating that she had not menstruated since October 21, and that her temperature curve had not dropped since the last upswing on November 10 to November 13, during which period she had sexual contact four times. On physical examination her breasts were definitely enlarged and her areolae and nipples brownish. Her uterus was larger than at the last examination and the cervix was soft. A Friedman test was positive. The rest of her gestation was quite uneventful and she delivered a 6½ pound normal female child on July 18.

The postpartum checkup revealed an involuted, anteflexed uterus with a uterine index of 0.76. The patient was advised to return in 6 months to have the index rechecked as to the prognosis for further childbearing.

DISCUSSION AND SUMMARY

The case of an infertile woman, having a hypoplastic uterus, a low basal metabolic rate and a mild anemia is described. She was treated with hormone injections, thyroid, iron and the timing of intercourse according to her Basal Temperature Graphs. After relief of the causative factors of her sterility the patient became pregnant and delivered spontaneously a normal female child which she was able to nurse herself. The fact that the patient became pregnant with a Uterine Index of only 0.56 (still below 0.60, indicating a hypoplasia of clinical significance[3]) was probably due to the fact that a U.I. of 0.56 can be considered as borderline; furthermore, and even more important is the presence of a normal endometrium which was able, though irregularly, to undergo proliferative and secretory phases. In connection with hormone injections, the importance of giving hormones at the correct time and in the right dosage is obvious: only by careful appliance of these drugs can we hope to improve such deficiencies.

Assuming that the hypoplastic uterus was due to an ovarian insufficiency, the treatment substituted the diminished estrogen. Progesterone was given to regulate the menstrual intervals. Lane-Roberts[4] gives 1.5 to 2.5 mg. of estrone weekly in the form of an intramuscularly injected microcrystalline suspension (page 313); the uterine index has to be checked regularly every four to six weeks; the estrogen causes uterine development and also increases its vascularity. Gonadotropins have to be used with caution in his opinion, because in many cases of uterine hypoplasia

* The solution recommended was Nutri-Sal, which is tradenamed by Ortho Pharmaceutical Corporation.

2. Schering Corporation's trade-name for U.S.P. progesterone.
3. Meaker, S. R.: Human Sterility: Causation, Diagnosis and Treatment (1934).
4. Lane-Roberts, C.: Sterility and Impaired Fertility (1948).

these hormones are excreted in normal or even excessive amounts in the urine; the cause in such a case is a change in reactivity to the ovarian hormones, an inherent or acquired incapacity to react to the ovarian stimulus. He further elaborates that gonadotropin analysis of the urine is useful for the identification of endocrine syndromes, but is often of even greater value as a corroboration of diagnosis based on study of signs and symptoms. S. L. Siegler[5] recommends injections of 50,000 I.U. of estradiol benzoate every third day for seven doses, repeating that course several times after menses; an increase of the size of the uterus will result if a normal pituitary-ovarian relationship is present.

Dilatation and curettage have been performed rather frequently with the aim to stimulate by way of the pituitary gland. In cases of an unhealthy endometrium, this procedure can well be accepted, but otherwise many women have probably been rendered permanently sterile by this radical operation.

The application of a pessary in an anteflexed uterus has undoubtedly helped to dip the portio in the seminal pool but is obviously without value if the treatment of the hypoplastic uterus as such is neglected. Mazer and Israel[6] who claim that habitual abortion can be caused by hypoplasia of the uterus due to its diminished size, incomplete development of the decidua and neurogenic hypertonicity during pregnancy treat this condition by estrogen and repeated cervical dilatations for the reason mentioned above, stimulation via the pituitary gland.

184 Livingston Avenue

5. Siegler, S. L.: Fertility in Women (1944).
6. Mazer, C., and Israel L.: Menstrual Disorders and Sterility (1951).

THE EASTER SEAL APPEAL

Between March 13 and April 13, 29 million American homes will receive through the mails a gaily colored sheet of Easter Seals. Accompanying these bright symbols of hope will be a letter asking support for the National Society for Crippled Children and Adults.

It is a cause in which the doctors of this nation have both a keen interest and a large stake. Thousands of medical practitioners in all the states participate in the work being done by the Society and its affiliates. Since its founding in 1921, hundreds of physicians have been actively working with these National Society affiliates as advisers, counselors and consultants.

Planning and development of Easter Seal programs are done at the national level and under the direction of the appointed liaison officers of the American Medical Association, medical specialty groups and other allied professional organizations. Similarly, at the state and local levels, advisory committees and councils composed of physicians, educators and other professionally trained persons guide service programs.

The doctors' stake in this great nationwide network of facilities and services is two-fold. It is through the specific facilities maintained by the Easter Seal societies and through the services of more than 2000 professionally trained persons such as therapists, psychologists, medical social workers and educators they employ that doctors find the treatment and training for crippled children which augment their own efforts.

It is significant to American doctors, also, that this cause is a great voluntary effort, representing the American people's way of providing help for those who are unable to obtain it for themselves. It is a cause which demonstrates dramatically the sense of individual responsibility for one's neighbor. Last year this help was extended to 228,000 crippled children and adults.

Because this is a voluntary effort, the major sources of support for these services is the American people themselves. The annual Easter Seal appeal began in 1934 and today has the support of millions of small donors throughout the nation, rather than large corporate contributors.

This appeal needs the support of the medical profession. In a period of rising costs, services for crippled children, always expensive, will cost more than ever before. It cannot fall short because it will mean curtailment of existing service.

Doctors of this nation can share the leadership in seeing that this 1952 Easter Seal appeal is successful, thus once more showing their fellow Americans that where there is a need, the doctor will find a way.

CLINICAL RESULTS WITH PRANTAL METHYLSULFATE *

A NEW PARASYMPATHETIC BLOCKING AGENT

PRELIMINARY REPORT

W. F. Vogel, M.D., Paterson, N. J.

The quest for improved chemical compounds for the treatment of peptic ulcer continues. Ever since the introduction of tetraethylammonium, other and similar chemical compounds have been developed with the hope of finding a therapeutic agent with sufficient parasympathetic blocking action to reduce gastric motility and secretion. Such a drug should be effective orally and act selectively upon the stomach. The most widely known drug of this type is Banthine† on which the first clinical trials were reported by Longino[1] and his coworkers in 1950. Subsequently, a voluminous literature evolved about this new compound. Many other investigators have confirmed the early findings, and today Banthine† is recognized as a valuable adjunct to the treatment of peptic ulcer. The disadvantages of Banthine† are its undesirable side effects, such as dryness of the mouth, mydriasis, cycloplegia, constipation, urinary retention (in cases of prostatic hypertrophy) and, sometimes, nausea and vomiting during initial administration of the drug. These side effects are encountered frequently.

The search for a new drug which would have the same or better parasympathetic ganglionic blocking action but no undesirable side effects led to the development of N,N-dimethyl-4-piperidylidene-1,1-diphenylmethane methylsulfate, a new quaternary ammonium compound, which has been named Prantal.*

PHARMACOLOGY

Pharmacologic studies[2] in animals have shown that Prantal* has a greater parasympathetic blocking action than Banthine† when compared orally. The sympathetic ganglionic blocking action was determined by administering Prantal* intravenously to cats and dogs. It was found that the dosage required was 50 to 100 times higher than the one needed to achieve parasympathetic blocking.

The intravenous toxicity of these drugs was also measured in dogs. Prantal* was found to be one-half as toxic as Banthine.† Death from each drug was due to respiratory failure.

Effect of Prantal Methylsulfate* and Banthine† on the gastric secretion of dogs anesthetized with chloral hydrate were examined. Evaluation was made by comparing gastric juice flow collected before and after the injection of the drug. Collection of secretion was continued until the drug inhibitory effect disappeared. The results indicate the following:

1. The intravenous injection of as little as 0.05 milligrams per kilogram of Prantal Methylsulfate* caused a marked reduction in the normal gastric juice flow. There was also an impressive reduction in the titratable free and total acid.
2. In anesthetized dogs the copious gastric flow elicited by the subcutaneous injection of histamine dihydrochloride was reduced by the intravenous administration of a milligram or more of Prantal Methylsulfate* per kilogram of body weight.
3. Prantal Methylsulfate* was more effective than Banthine† in suppressing secretion.

Gastro-intestinal motility changes in dogs were studied radiographically. Prantal* and Banthine† were given orally. As much as 50 per cent gastric retention after six hours could be observed. Prantal* proved superior to Banthine† in comparable tests. Banthine† did cause mydriasis in these tests while Prantal* did not.

The mydriatic activity was tested in the rabbit by dropping varying concentrations of either drug on the surface of the rabbit eye. A tenth of one per cent solution of Banthine† caused mydriasis whereas a tenfold concentration of Prantal* did not. At least a fourfold difference in causing this action exists in favor of Prantal* when the drugs were given intravenously.

It seemed from these studies that Prantal* would have considerably fewer side effects than Banthine† when administered in therapeutic doses to man.

CLINICAL STUDIES

Prantal* was given to fifteen patients to determine the clinical properties of the drug. Four of these patients had previously received Banthine,† so that comparison between the two drugs was possible. In another second group of eleven cases no ulcer therapy had been given previously. These patients began with a routine ulcer regimen consisting of a modified Sippy diet and Prantal.* Antacids

* Prantal was supplied by the Schering Corporation, Division of Clinical Research, along with a grant-in aid.

† A brand of methantheline bromide tradenamed by G. D Searle and Company.

1. Longino, F. H.; Grimson, K. S.; Chittum, J. R., and Metcalf, B. H.: *Gastro-enterology*, 14:301 (1950).

2. Hemingway, N. L.: Personal communication to the author.

were not permitted in this group. The time required to render the patients symptom-free and (when possible) the total time needed for the ulcer to heal were noted. Especial care was taken to note any possible side actions attributable to the drug. An abstract of the salient features of each case in which Prantal* was studied follows:

CASE ONE

A 63-year old housewife had complained of "gas and belching" all her life. In 1942 x-ray revealed a gastric ulcer on the lesser curvature near the fundus. Gastroscopy was confirmatory. Under conservative therapy her symptoms improved except for some gas and belching. During November 1950, a repeated x-ray series disclosed an area of irregularity at the previous ulcer site. A gastric analysis with caffeine test meal showed normal values for free hydrochloric acid. Although a diagnosis of an active ulcer was not made, Banthine† 100 milligrams for the first morning dose followed by 50 milligrams every six hours was administered in an effort to relieve the epigastric distress and belching. A bland diet with antacid medication was the only other measure employed. Some improvement was noted with this regimen. Dryness of the mouth in the morning, however, necessitated a shifting of the larger dose to the last one in the evening. The dryness of the mouth and bitter taste became less marked though still present. After four weeks, Banthine† was reduced to 50 milligrams t.i.d. because of marked general improvement. She remained on this maintenance dose for nine months when some pain under the left costal arch was again felt. Banthine† was discontinued and Prantal* 50 milligrams every six hours was administered. The bland diet and antacids were continued. Pain subsided after two weeks and there were no unpleasant side effects. Prantal* was increased to 100 milligrams four times a day in effort to stop the persistent belching and epigastric discomfort. This was not achieved and the dose was reduced to 50 milligrams q.i.d. for five and one-half weeks. By that time all symptoms had improved so that the patient felt well enough to discontinue all medication. In this case Prantal* was equal in therapeutic action to Banthine† and had the advantage of not producing undesirable side effects.

CASE TWO

A 67-year old male had a history of intermittent epigastric distress for seventeen years. During a marked exacerbation in January 1949, an x-ray series revealed an irregular duodenal cap with spasm of the duodenum and a diverticulum of the second portion. Symptoms subsided on a routine ulcer regimen. He felt well until late summer of 1950 following severe abdominal pain accompanied by nausea and vomiting. X-ray series now showed a severely deformed duodenal bulb. Banthine† 100 milligrams every six hours and a progressive modified Sippy diet were prescribed. The patient improved and returned to work three weeks later. A maintenance dose of Banthine† (50 milligrams every six hours) was taken until February 1951. During this time he complained of some dryness of the mouth. This was not severe enough to discontinue Banthine.† During May 1951, ulcer symptoms were again noted. Banthine† 50 milligrams every six hours and the modified ulcer diet were reinstituted. Improvement permitted the patient to return to work four weeks later. A maintenance dose of Banthine† (50 milligrams q.i.d.) was continued because of the frequent recurrences. At this time the patient complained of such severe dryness of his mouth that he often was unable to talk for two hours following ingestion of the tablets. Nevertheless, he took the medicine faithfully.

On August 2, 1951, Prantal* 50 milligrams every six hours was started and Banthine† discontinued. There were no side effects with Prantal* and the epigastric symptoms were controlled equally well, though never absent. X-ray series two months later showed a markedly deformed duodenal bulb and a definite ulcer niche. Accordingly Prantal* was increased to 150 milligrams in the morning to be followed by 100 milligrams every six hours. No untoward side effects appeared with this increased dosage. The ulcer symptoms decreased rapidly and within two weeks the patient was almost symptom-free.

In this case the following conclusions could be drawn: with proper diet, antacids and parasympathetic blocking agents ulcer symptoms could be controlled. It was possible to increase the dose of Prantal* to more than double the customary dose used with Banthine† without precipitating side effects. It was possible to relieve this patient of active ulcer symptoms so completely with Prantal* that clinical healing could be assumed.

CASE THREE

A 49-year old male had a history of melena in 1942. Duodenal ulcer was diagnosed at that time. Following routine ulcer therapy he remained well until June 1951, when epigastric distress and pain occurred two hours after meals. Gastro-intestinal series showed a markedly deformed and tender duodenal bulb and a 30 per cent gastric retention after five hours. Treatment consisted of a modified Sippy diet and antacids augmented by 50 milligrams of Banthine† every six hours. He became symptom-free within a few days and returned to work two weeks after onset of that treatment. Banthine† caused moderate dryness of the mouth and constipation. After four weeks, the night dose was omitted and antacids were discontinued. X-ray series after five weeks of therapy showed a deformed bulb which was not tender. A trace of barium remained in the stomach after five hours. Because of these x-ray findings, the patient was given Prantal* 50 milligrams every six hours for four weeks. He was completely symptom-free during that time and has remained well for two months following cessation of all medication.

In this case, a maintenance dose of 50 milligrams of Prantal* proved to be equal to Banthine† in its therapeutic effect but avoided the side effects such as dryness of the mouth and constipation observed with Banthine.†

CASE FOUR

A 43-year old machinist complained of epigastric distress, a burning sensation below the xiphoid process, and belching which had existed at intervals for many years. X-ray studies were negative. Gastroscopy showed a beginning hypertrophic gastritis. Previous treatment having been unsuccessful, Banthine† was tried. The patient believed that he derived some benefit from this medication but there was a marked reduction in urinary flow and at times he was unable to void. Banthine† had to be discontinued, and an equivalent dosage of Prantal* was administered which, in the patient's words "seemed to help as well". The Prantal* did not cause urinary symptoms or other side effects. Prantal* was discontinued after two weeks because, like Banthine,† it failed to render this man symptom-free. Here is a case where no side actions due to Prantal* were noticed in a patient having urinary retention from Banthine.†

CASE FIVE

A 28-year old housewife complained of upper abdominal distress of three weeks' duration. There was point tenderness in the epigastric region. The x-ray series was negative except for a tender duodenal bulb. Although a diagnosis of duodenal ulcer was questionable, a routine ulcer regimen with 100 milligrams of Prantal* every six hours was administered for ten days. The symptoms disappeared and the patient remained well after the drug was discontinued. This case report is included as further reflecting the freedom from side effects when Prantal* is administered.

CASE SIX

A 45-year old female had complained of indigestion and food allergies for many years. The allergic symptoms could be controlled by omitting the offending agents but this caused considerable loss of weight. When first examined, she had a point of tenderness in the midline above the umbilicus. Gastro-intestinal series revealed a duodenal ulcer near the apex of the bulb. A modified Sippy diet was started, some allowances being made because of the allergy. At the same time, Prantal* 50 milligrams every six hours was administered. Within a week, most of the symptoms had disappeared. After two weeks, the patient was completely symptom-free. There were no side effects with the 50 milligram q.i.d. dosage but when the Prantal* was increased to 100 milligrams q.i.d., some blurring of vision and dryness of the throat and mouth occurred. The dose was again reduced to the 50 milligram level and all side actions disappeared. After eight weeks, Prantal* was discontinued as the patient was completely symptom-free.

CASE SEVEN

A 36-year old male complained of pain and epigastric distress for many years. X-ray examination revealed a duodenal ulcer at the base of the cap of the duodenum and enlarged gastric folds. This latter finding was not confirmed on gastroscopic examination. The patient began with a routine dietary regimen augmented by Prantal* 50 milligrams every six hours. One week later he was symptom-free. There were no side effects due to Prantal.* After nineteen days of treatment, the patient returned to work. There was no recurrence of symptoms and after seven weeks, Prantal* was discontinued. Two months later, at the time of this writing, the patient is still symptom-free.

CASE EIGHT

A 31-year old female was hospitalized, complaining of severe epigastric pain which had troubled her periodically for four years. She had chronic constipation and found it necessary to take enemas at frequent intervals. Gastro-intestinal series revealed an irregular and irritable duodenal bulb with a fleck of barium near the apex on the posterior aspect. Gastroscopic examination showed no abnormal findings. Gastric analysis, using an alcohol test meal, elicited a typical climbing curve for free hydrochloric acid. Because of the severity of symptoms, surgery was suggested, but the patient refused. She was placed on a modified Sippy diet augmented by Prantal* 50 milligrams every six hours. She became symptom-free after four days and was discharged from the hospital one week later. Prantal* was discontinued after six weeks and the patient continued to remain symptom-free. Constipation did not occur during this regimen which did not include laxatives.

CASE NINE

A 71-year old male was hospitalized on September 3, 1951, complaining of epigastric distress and pain for several weeks. X-ray examination revealed a duodenal ulcer crater on the anterior wall near the lesser curvature. The bulb was grossly deformed. Some amelioration of symptoms was observed following a routine Sippy diet with antacids although the symptoms never disappeared completely. On September 13 Prantal* 50 milligrams every six hours was added to his treatment. Further improvement in the symptomatology was noted, permitting him to leave the hospital in two weeks. X-ray examination at that time showed a nontender but irritable duodenal bulb with a small fleck of barium about two millimeters in diameter. The ulcer diet was continued and Prantal* was increased to 100 milligrams every six hours. The patient's only complaint now was "hunger pains" at night. He was advised to take an additional 50 milligrams of Prantal* before retiring, which brought the total daily dose to 450 milligrams. This was well tolerated. On subsequent x-ray examination on November 15 the previously demonstrated ulcer niche could not be seen although the deformity of the bulb was still present. Prantal* was discontinued on November 26 after a total period of ten weeks. The patient continues to be symptom-free at this writing.

CASE TEN

A 58-year old male was hospitalized in February 1951, with hematemesis. He made an uneventful recovery and was discharged. A gastro-intestinal series at that time (and those performed subsequently) have shown a constant narrowing of the second portion of the duodenum. This is believed

to be indicative of an ulcer at the second portion of the duodenum.[3] When the patient returned to the clinic in September, he was given a general ulcer diet together with Prantal* 50 milligrams every six hours. Although there was some improvement, the dose of Prantal* was increased to 50 milligrams daily. He became completely symptom-free within less than a week at this dosage level, and after four weeks, medication was discontinued. A gastric analysis using the caffeine test meal, after Prantal* had been discontinued, demonstrated low values for hydrochloric acid, the highest being six clinical units.

CASE ELEVEN

A 65-year old male was hospitalized in 1949. Gastro-intestinal series revealed a small duodenal ulcer. During the spring of this year symptoms of epigastric distress returned. Gastric analysis, using the caffeine test meal, showed a typical rising curve. This patient was seen again on October 26, 1951, because of an exacerbation of his epigastric symptoms, and he was given Prantal* 100 milligrams every six hours. Within three days he was rendered symptom-free. Prantal* was continued for four weeks. Six weeks have since elapsed and the patient remains symptom-free.

CASE TWELVE

A 61-year old male with a typical ulcer history, was seen during the fall of 1951. X-ray series revealed duodenal ulcer. A modified Sippy diet together with Prantal* 100 milligrams every six hours was started. Within five days the patient was practically symptom-free. Diet was increased and after four weeks his ulcer was considered in remission. He continued on a general ulcer diet together with Prantal* 100 milligrams four times a day for two weeks more. The night secretion of gastric juice was measured prior to Prantal* therapy. High values for free hydrochloric acid were observed, the highest being 64 clinical units and 85 for total acidity. After oral Prantal* therapy, gastric analysis was repeated and Prantal* was continued during the test at regular intervals. The highest value for hydrochloric acid was 50 units, but in four consecutive specimens during the morning hours no acid was present and all other values were markedly lower than before. The amount of gastric juice was about the same before and during treatment.

CASE THIRTEEN

A 25-year old male for the last two years complained of epigastric distress occurring two hours after meals although it was usually relieved by milk. Gastric analysis with a caffeine test meal showed a high prolonged curve for free hydrochloric acid. X-ray series revealed duodenal ulcer. The patient was placed on a modified Sippy diet and 100 milligrams of Prantal* every six hours. He is continuing now on a general ulcer regimen. He remained symptom-free and returned to work after three weeks of treatment. Prantal* was continued for another two weeks and now the patient is symptom-free without medication.

3. Lonergan, W. M., and Kahn, A., Jr.: *Gastro-enterology*, 17:494 (1951).

CASE FOURTEEN

A 31-year old female had an ulcer history for four years. In 1951, a gastro-intestinal series revealed an irritable duodenal bulb and a fleck of barium in the postbulbar region. Routine ulcer therapy always improved her condition sufficiently so that she could do her daily work. In the fall of 1951, she reported symptoms suggestive of an active duodenal ulcer. She was given a modified Sippy diet together with Prantal* 100 milligrams every six hours. She was symptom-free within a week and has continued to feel well. Prantal* was discontinued after four weeks of therapy. An x-ray series performed two months after the onset of treatment revealed a normal duodenal bulb. A gastric analysis, using the caffeine test meal, performed after treatment showed a normal curve for free hydrochloric acid, the values ranging from 16 to 32 clinical units.

CASE FIFTEEN

A 61-year old male had an ulcer history for twenty years. He was first hospitalized in 1940. His second admission was in 1943 for a bleeding peptic ulcer, and his third in 1951 for exacerbation of ulcer symptoms. His condition has been aggravated over the years by the consumption of large quantities of alcohol. The gastro-intestinal series on this last admission revealed an ulcer niche along the lesser curvature. Gastric analysis after a caffeine test meal was 55 degrees at its highest point. The same value was obtained after Prantal* 50 milligrams every six hours. However, the patient could be rendered symptom-free within a week's time and was discharged from the hospital. Prantal* was continued for another four weeks and the patient remained symptom-free eight weeks after Prantal* was discontinued. Gastric analysis showed the same value before and after treatment although the symptoms disappeared.

Table I comprises the cases of group I. These four patients were previously treated with Banthine† and were later changed to Prantal.* The therapeutic effects of both drugs, as far as the control of ulcer symptoms was concerned, were equally good with the exception of case 2; however, each of the patients encountered one of the usual side effects while under Banthine.† Prantal* did not elicit any of these side effects. Case Two deserves special mention: Because of dryness of the mouth, the dose of Banthine† could not be increased, although it was desirable from a therapeutic standpoint. The amount of drug could be more than doubled with Prantal,* without undesirable side effects, and the patient was rendered symptom-free. Case four showed signs of urinary retention, which is an absolute indication for discontinuance of Ban-

thine.† Prantal* failed to produce any undesirable side effects. This suggests that Prantal* is equivalent to Banthine† in therapeutic effectiveness, milligram for milligram. Because of its relative lack of side effects, Prantal* can be given in higher dosages than Banthine† when necessary to control the difficult case.

The patients summarized in Table II were those who did not receive any other drug prior to treatment. Only one patient exhibited undesirable side effects—dryness of the mouth and blurred vision—when a dose of 100 milligrams every six hours was given. Reduction of the dosage to 50 milligrams every six hours relieved the ulcer symptoms equally well without undesirable side effects. In only one case, nine, were antacids used concomitantly with the usual dietary regimen and Prantal.* All of the patients were given a modified Sippy diet and Prantal.* If it became evident that 50 milligrams of Prantal* every six hours was not sufficient to control the ulcer symptoms, the dose was doubled. All patients were rendered symptom-free within three days to one week after beginning treatment. It is true that similar results can be obtained with a Sippy diet and one of the older drugs such as belladonna or Banthine;† however, no one has reported better clinical results than those here cited, when using any of the older drugs. Prantal* seems superior in most cases, it allows a higher dosage without undesirable side effects. This permits medical therapy in many patients who would have had to be treated surgically previously.

The influence of Prantal* on gastric secretion was tested in two cases. Case 15 showed no reduction in free hydrochloric acid when the caffeine test was done; however, the dosage of Prantal* was only 50 milligrams every six hours. Case 12 exhibited a marked reduction of free acid during a night secretion study when 100 milligrams of Prantal* were administered orally, prior and during the test, at six hour intervals. The amount of gastric juice remained the same before and after administration of Prantal.* Kirsner[4] and co-

TABLE I.

Case	Dryness of Mouth		Blurred Vision		Suppressed g-colic reflex		Urinary Retention	
	B	P	B	P	B	P	B	P
1	x	O	x	O	O	O	O	O
2	xx	O	O	O	O	O	O	O
3	x	O	O	O	x	O	O	O
4	O	O	O	O	O	O	x	O

TABLE II

Case	Prantal* mgms/q.6.h.	Symptom-free After	Prantal* Given for	Side Effects	Diagnosis
5	50	5 d	10 d	O	Functional
6	50 to 100	10 d	6 w	D.M.	Du.U.
7	50 to 100	7 d	7 w	O	Du.U.
8	50	4 d	6 w	O	Du.U.
9	100	7 d	10 w	O	Du.U.
10	100	7 d	8 w	O	PBU
11	100	3 d	4 w	O	Du.U.
12	100	5 d	6 w	O	Du.U.
13	100	3 d	4 w	O	Du.U.
14	100	7 d	4 w	O	Du.U
15	150	3 d	4 w	O	Du.U.

ABBREVIATIONS:
B: Banthine 50 milligrams every six hours, orally.
P: Prantal 50 milligrams every six hours, orally; except case 2, see text.
O: Symptoms not present.
x: Symptom present.
d: Days.
w: Weeks.
DM: Dry mouth.
PBU: Posterior bulb ulcer.
Du.U.: Duodenal ulcer.

workers reported secretion studies of twenty-two patients and demonstrated a reduction in hydrochloric acid and quantity of gastric juice when Prantal* was used. They stated that the necessary dose varied from patient to patient. A similar conclusion can be drawn from the cases reported here. While the first few patients were routinely started on 50 milligrams per dose, later all patients were treated with at least 100 milligrams every six hours, and the amount of the drug was increased if clinical symptoms warranted it. If side effects occurred, the dose was reduced to the highest tolerable level. Optimal effective dose was thus determined. As cases now under treatment show; 500 to 600 milligrams daily are well tolerated by most patients. How often it is possible to reduce gastric secretion, both in amount and in free acid, to a level now considered essential for effective ulcer treatment, was not investigated in this study.

Antacids were not used in group II, but it is safe to say that clinical improvement was as rapid as could be anticipated with any of the common forms of treatment. This permits the assumption that Prantal* contributed greatly to the control of ulcer symptoms and promoted the healing of the peptic lesion. From the few cases reported, it seems permissible to draw the conclusion that the pharmacologic properties of Prantal* are equal or superior to those of other parasympathetic ganglionic blocking agents now in use.

Blood pressure and temperature readings were taken on all patients. Routine laboratory tests such as urinalysis and blood counts were regularly performed. No alterations due to Prantal* therapy were observed.

The impression is gained from these fifteen cases that Prantal* is superior to any of the available parasympathetic blocking agents now available for treatment of peptic ulcer. The lack of side effects permits a higher dosage which makes it possible to render the patient symptom-free earlier and to bring about relief and healing of the lesions formerly unresponsive to medical management. It is advantageous to use doses of 100 to 200 milligrams every six hours in cases of acute ulcer. To control gastric secretion effectively, the dose should be higher than the one required to bring about clinical improvement alone. In most of the cases reported here, after four weeks of therapy with Prantal,* subsequent x-ray studies revealed healing of the lesions observed on the initial gastro-intestinal series. After the ulcer had healed, a maintenance dose of 50 milligrams four times daily was prescribed for another month. All patients were instructed to take the medicine upon the return of ulcer symptomatology. Further study will determine whether the incidence of relapse is decreased.

SUMMARY

Fifteen cases of duodenal ulcer or ulcer-like syndromes were treated with Prantal,* a new parasympathetic blocking agent. The usual modified Sippy diet was used, while antacids were omitted in most instances. It was found that Prantal* was superior to any of the currently available compounds of similar pharmacologic action. Undesirable side effects were rarely observed. In no case was it necessary to discontiue the drug because of side effects. When Prantal* was used in sufficiently high dosage, those patients previously regarded as treatment failures (either from failure of conservative therapy or intolerance to the drug used) could be rendered symptom-free. It was shown that Prantal* by oral administration reduces the production of hydrochloric acid in the stomach. It is hoped that this short report will serve as a stimulus for others to investigate this new and interesting drug.

4. Kirsner, J. B.; Palmer, W. L.; Levin, E., and Klotz, A. P.: Annals of Internal Medicine, 35:785 (July 1951).

546 East 29th Street

STATE ACTIVITIES

THE JAMES F. NORTON MEMORIAL FUND, INC.

The good that men do sometimes lives after them. This fact has been encouragingly demonstrated through the recent establishment of the James F. Norton Memorial Fund. Incorporated in Hudson County, this Fund was inspired by the discovery that the last check written by Dr. Norton before his untimely death in September 1950, was for $500, for the tuition of a young man entering medical school. A group of his colleagues have decided, through the establishment of this Foundation, to continue and expand the generous and important work which Dr. Norton himself thus began. It is their dream that Dr. Norton shall have a living memorial in New Jersey through the lives and services of the men and women doctors of the state whose careers this Fund will make possible.

Loans of from $1000 to $1500 will be made each year to students who have been accepted by qualified medical schools but who have insufficient funds to see themselves through. Student borrowers will reimburse the Fund in annual installments, commencing five years after their graduation.

Dr. Joseph P. Donnelly, Secretary of the Fund, announces that contributions amounting to $5000 have already been pledged by the Hudson County physicians who have initiated the movement. Friends of Dr. Norton everywhere, both within and without the medical profession, are invited to share in this new and worthy venture. Contributions may be sent to the James F. Norton Memorial Fund, Inc., at the Margaret Hague Hospital, Jersey City.



JAMES F. NORTON, M.D.

President, The Medical Society of New Jersey
1949-1950

Vice-President, American Medical Association
1949-1950

Here is a means of honoring the past and serving the future of medicine in New Jersey.

N. J. DIABETES ASSOCIATION MEMBERSHIPS AVAILABLE

Announcement is made of the availability of memberships in the New Jersey Diabetes Association. Interested physicians should communicate with the chairman of the membership committee, Dr. George M. Knowles of 5 Pangborn Place, Hackensack; or with the secretary, Dr. Everett O. Bauman, of 862 South 13th Street in Newark.

AIR FORCE COMMISSIONS NOW AVAILABLE

The United States Air Force has announced a program whereby commissions will be offered to young men and women practicing in all fields of medicine and in all allied specialized vocations.

The list of vocations includes doctors of preventive medicine, gastro-enterologists, obstetricians, gynecologists, allergists, anesthesiologists, ophthalmologists, otorhinolaryngologists, neurologists, internists, general and orthopedic surgeons, radiologists, oral surgeons, periodontists, prosthodontists, medical supply and medical equipment maintenance specialists, sanitary engineers, clinical laboratory technicians, general duty and anesthetists' nurses, dieticians and physical therapists.

Each classification has a different set of requirements for each grade. Inquiries should be directed to the Air Surgeon, First Air Force, Mitchell Air Force Base, New York.

OBSTETRICAL-GYNECOLOGY CONGRESS

The American Congress on Obstetrics and Gynecology will meet in Cincinnati, Ohio, March 31, through April 4, at the Netherland Plaza Hotel. This session will feature a comprehensive five-day scientific program covering all aspects of the maternal care team.

Meetings will be devoted to dystocia, sterility, urinary incontinence, uterine carcinoma, obstetric hemorrhage, ovarian tumors, toxemias, and fetal wastage. Panels will consider complications of puerperium, Rh and Hr sensitization, maternal mortality, lesions of the vulva, endometriosis, pregnancy complicating medical conditions, uterine bleeding, and cesarean section. Discussions will follow each presentation. Arrangements have been made for submittal of written questions by mail or at the Congress.

Highlight of the public health program will be an initial report on the results of a new study of 10,000 neonatal deaths by the Chicago Health Department. An afternoon program will analyze the causes of the infants' deaths and recommendations on how these could be reduced further.

Congress registration fees are $5. for members and $10. for non-members. Further information, registration or reservations can be obtained by writing to the Executive Secretary, American Committee on Maternal Welfare, 116 South Michigan, Chicago 3, Illinois.

CHEST DISEASE COURSE

The fifth annual Postgraduate Course in Diseases of the Chest sponsored by the Pennsylvania Chapter of the American College of Chest Physicians and the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, Philadelphia, March 24 to 28, 1952.

A program covering the entire field of heart and lung disease is being arranged. Dr. Chevalier L. Jackson is chairman of the postgraduate course committee.

Physicians interested in attending the graduate course should communicate with the American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Ill.

NEW DIABETES JOURNAL LAUNCHED

A new journal, called simply *Diabetes,* made its bow last month, with the February 1952 issue. Published by the American Diabetes Association, it is edited by F. N. Allan of the Lahey Clinic, and counselled by a distinguished editorial advisory board headed by Dr. Charles Best. Both the clinical and research aspects of diabetes will be covered. Subscription rate, for non-members of the American Diabetes Association, is $9 a year. *Diabetes* will be sent without charge to members of the Association. Manuscripts and subscriptions are sent to Editorial Office, American Diabetes Association, at 11 West 42d Street, New York 18, N. Y.

NEW NEW JERSEY F.A.C.S.'s

At its recent convocation, the American College of Surgeons initiated into Fellowship, the following New Jersey residents:

William T. R. Cox, Elizabeth
Thomas C. Davis, Millburn
William J. Follette, Englewood
Francis J. Grant, Hillside
Otto Lehmann, Long Branch
Robert L. Lieb, Newark
Herman Lohman, Newark
Irving Marshall, Jersey City
Frank M. Mastroianni, Elizabeth
Herschel S. Murphy, Roselle
Graham C. Newbury, Summit
Dennis M. O'Brian, Passaic
Paul A. O'Connor, Newark
Earl A. O'Neill, Plainfield
Hyman Oren, Park Ridge
F. Leland Rose, Camden
Samuel Louis Sloan, Paterson
Joseph M. Smolev, Passaic
Arthur G. Solk, Newark
Michael M. Spirito, Elizabeth
Abram Vermeulen, Prospect Park
Henry Paul Wager, Jersey City
Louis S. Wegryn, Elizabeth
David Wiener, Newark
Arthur T. Willetts, Summit
Egon W. Winter, Newark
John S. Wise, Trenton
Herbert M. Wolff, Trenton

OBITUARIES

DR. JOHN P. BRENNAN

Dr. John P. Brennan, widely known Camden nose and throat specialist, died of a heart condition on January 12, 1952.

Dr. Brennan, who was 58, received his medical degree from Jefferson Medical College in 1918. He was a member of the staff of Our Lady of Lourdes Hospital and was former president of the staff at Lakeland General Hospital.

DR. JOSEPH G. COLEMAN*

Dr. Joseph G. Coleman, senior Trustee of The Medical Society of New Jersey, died on February 1, 1952, at the age of 77. Born in Goshen, New York, he attended Albany Medical College from which he was graduated at the age of 22. He came to Sussex County, New Jersey, and there he practiced for 53 years. Most of that time, he lived in Hamburg, New Jersey, and was on the borough council, board of education, and the county election board. In 1901 he was elected president of the Sussex County Medical Society. He served as commander of both the local post and county organization of the American Legion, having been on active duty as a major in the medical corps during World War I. He was a member of the Welfare Committee of The Medical Society of New Jersey and for the last 9 years was on the Board of Trustees of this society.

DR. IRA FLAX

Dr. Ira Flax of Newark, died on January 26, 1952, after a short illness, at the age of 49.

Dr. Flax was graduated from the University of Maryland Medical School in 1924. He was a specialist in proctology and was on the staff of Beth Israel, City and Lutheran Hospitals, and was on the consulting staff at Lyons Veterans Hospital.

DR. ELMER E. GEISSLER

Dr. Elmer E. Geissler, Gloucester City, died on January 13, 1952, following an illness of three weeks.

Dr. Geissler was born in Gloucester City in 1887. He received his medical degree from Temple University Medical School in 1918. Following World War I he was company physician for the Pennsylvania Railroad in Pittsburgh, and later for Bethlehem Steel Corporation in Johnstown, Pa. He was public school physician in Gloucester City since 1934.

DR. SAMUEL F. GORSON

Dr. Samuel F. Gorson, chief in the neurology and psychiatry department of Atlantic City Hospital, died suddenly on January 26, 1952, at the age of 59.

Dr. Gorson was graduated from Jefferson Medical College in 1915. He later returned to Jefferson as an instructor in Neurology. He was also on the staff of the Betty Bacharach Home.

* For editorial comment on the death of Dr. Coleman, see page 88 this issue.

Medical-Surgical Plan of New Jersey

"New Jersey's Blue Shield Plan"

When this issue of the Journal reaches you, it is expected that Medical-Surgical Plan's revised Schedule of Payments will be in effect, and that each Participating Physician will have received a loose-leaf binder containing a complete "Manual of Information" about the Plan, including the new Schedule.

Distribution of this Manual marks the first time that the Plan has provided each Participating Physician with a single compendium containing all the information he needs to conduct his daily business with the Plan.

The new Schedule of Payments contains many changes from the Schedule heretofore in use. Every such change has been based upon recommendations made to the Plan by officers and designated representatives of the various professional groups who conferred with the Plan during the long period in which this Schedule was in preparation.

In the strictest sense, the new Schedule represents the considered opinion and advice of the profession itself as to a fair and equitable average payment for the various professional services listed, with reference to subscribers whose annual income at time services are rendered is not in excess of $5000.

It should be emphasized, however, that regardless of the amount of thought and care that goes into the preparation of this (or any other) Schedule, there are certain to remain some listings which, to some physicians, will seem to be out of relation, perhaps, to certain other items. The Plan welcomes suggestions from any Participating Physician as to improvements that may be made either in the Schedule, itself, or in respect to procedures of the Plan.

Having completed its long-awaited Schedule of Payments and Manual of Information for Participating Physicians, the next major step in the evolution of Medical-Surgical Plan will be the development of a new Subscription Contract. Preliminary conferences with representatives of Hospital Service Plan, which acts as the enrollment agent for Medical-Surgical Plan, have developed several proposals for major changes in the Subscription Contract which should make the Contract more attractive to present and prospective subscribers and to the medical profession.

At the same time, during February, the Plan has been holding a series of conferences with members of the Advisory Committees to Medical-Surgical Plan which have been designated by each of the twenty-one County Medical Societies. The purpose of these meetings has been not only to establish a more effective liaison between the Plan and the profession in each County, but specifically to consult the profession in regard to possible changes in the Plan's Contract that are of particular interest to the medical profession.

After these district conferences have been completed, the consensus will be reported to The Medical Society of New Jersey and further consideration on a statewide basis will be given to various proposed changes in the Contract.

The Plan looks upon each of its more than 5000 Participating Physicians as a co-worker in the enterprise of providing an ever improved medical service program for the citizens of New Jersey.

James E. Bryan, Administrator.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, January 11, 1952, Dr. Anthony G. Merendino presiding.

THOMAS M. MCMILLAN, M.D., F.A.C.P., professor of Clinical Cardiology, University of Pennsylvania, Graduate School of Medicine, was the guest speaker. His subject, "Newer Ideas in the Treatment of Cardiac Arrhythmia", was of great interest to both cardiologist and general practitioner.

Dr. Holland, reporting for Public Relations, distributed an outline of the program on Emergency Medical Service to the members present. Dr. Merendino urged members to properly recognize the importance of this undertaking and to give their whole-hearted support.

Dr. Oscar Harris read to the Society a set of resolutions commemorating the passing of Dr. Richard Mark Fowler. It was moved and seconded that the resolutions be adopted that they be inscribed upon the minutes of our Society, and that a copy be forwarded to the bereaved family.

Dr. Sasseen gave a final report on the plan to examine Temporary Disability Cases. He stated, in essence, that examinations will be made in the locality in which the patient lives, that examinations of cases treated by osteopathic physicians will be made by members of this Society, and finally that there will be no objection to the examining physician discussing the patient with the physician in charge.

Under new business, Dr. Ellenbogen announced that physician veterans of World War II were eligible for Social Security Benefits, depending on the number of years in service. For further information as to his status, the veteran should apply to the Social Security Administration in Baltimore.

Dr. Merendino regretfully announced the passing of another esteemed and respected member of our Society, Dr. Norman H. Bassett. Dr. Robert Bradley and Dr. Samuel Winn were appointed to draw up a suitable set of resolutions to be presented to the Society at the February meeting.

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

The annual meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on January 10, 1952, at 9:00 p. m. President T. B. DICKSON, M.D. officiated.

The guest speaker of the evening was DR. EUGENE B. SPITZ, Neurosurgeon at the Children's Hospital of Philadelphia and Associate in Neurosurgery, Medical School of the University of Pennsylvania. His subject was "Recent Advances in Pediatric Neurosurgery". In a most informative manner, Dr. Spitz outlined the current technics employed in diagnosing and treating the various types of hydrocephalus and noted the importance of early differentiation from a subdural hematoma.

At the business meeting, the following officers were elected for the year 1952-1953: President, DR. A. B. PEACOCK; President-Elect, DR. F. W. METZER; Vice-President, DR. L. E. VITERI; Treasurer, DR. W. P. MULFORD; Secretary, DR. R. T. BUCKLEY; Reporter, DR. W. F. BETSCH; Board of Censors, DR. P. R. SPARKS.

DR. SAMUEL B. BROWN of Burlington was elected to membership.

CAMDEN COUNTY

James P. Harbeson, III, M.D., Reporter

DR. WALTER A. CRIST, President, presided at the regular monthly meeting of the *Camden County Medical Society* on February 5, 1952. There were seventy members present.

The following doctors were elected to Active membership and introduced to the society: LUKE W. JORDAN, CHAUNCEY K. MCGEORGE, ROSCIUS L. DOWNS, ALAN A. ROGERS, MICHAEL E. NARDI and ANTHONY V. ZICCARDI.

HOBART A. REIMANN, M.D., spoke very informatively on the subject of "Prevention and Treatment of Diseases of the Respiratory Tract". His remarks dealt mainly with the virus diseases and he corrected a good many falacies in the current treatment of such entities. Drs. Sharp, Eynon, Goldstein and Decker offered short discussions.

Miss Christy, of the Visiting Nurse Society, made a plea that the doctors encourage nurse recruitment whenever possible.

CUMBERLAND COUNTY

Frank J. T. Aitken, M.D., Reporter

The February meeting of the *Cumberland County Medical Society* was held in the Kimble Glass Company in Vineland on February 12, 1952, at 2:30 p. m., with DR. E. C. GREENE presiding. Forty-four members were present at roll call.

This Society placed its approval on the monthly Cerebral Palsy Clinic presently active in the Millville Hospital under the auspices of the United Cerebral Palsy Clinics, Inc. Dr. Carl Ware reported some interest in the formation of a Woman's Auxiliary and a motion was made to notify Mrs. McGlade of this decision.

Dr. Charles E. Sharp of Port Norris made a critical and scholarly summation of the studies and purposes of the Truman Medical Commission which was appointed December 20, 1951. Dr. Albert B. Kump was appointed to recommend to the State Society an improved telephone listing of practicing county medical physicians. The Society went on record as approving Dr. Frank Aitken's candidacy for coroner for the forthcoming election. Dr. Kump was recommended to the State Society to fill the vacancy left by the resignation of Dr. Knowles as a member of the Field Committee on Maternal Welfare.

DR. J. GERSHWIN COHEN, assistant professor of Radiology, Graduate School of Medicine, University of Pennsylvania, spoke on the "Physics of Atomic Radiation", giving a historical synopsis and tracing the development of present nomenclature. DR. HARRY REINHART, F.A.C.R., Radiologist at the Newcomb Hospital in Vineland, further continued the

discussion of "Practical Uses of Radioactive Isotopes". Phosphorus, sodium, iodine, potassium and carbon were alluded to, or briefly discussed, also combinations and their special uses, and methods of measuring their dosage and absorption.

ESSEX COUNTY

Elizabeth R. Brackett, M.D., Reporter

The February 14, 1952, meeting of the *Essex County Medical Society* was held in the auditorium of the Beth Israel Hospital in Newark, with Dr. Kenneth Gardner, the president, presiding. Upon conclusion of the reading of the minutes of the last Council meeting, Dr. Gardner turned the meeting over to Dr. Kaplan, chairman of the Program committee of the Medical Staff of Beth Israel Hospital.

This was the fourth in our series of combined meetings and featured a program on the "Hepatitis Problem". Dr. Kaplan introduced the speaker of the evening, Dr. Henry J. Tumen, associate professor of Gastro-Enterology Graduate School of the University of Pennsylvania, who discussed the present conception of hepatitis with its commonly expounded virus etiology.

Following Dr. Tumen's presentation, the hospital residents presented some case reports involving the consideration of the hepatitis problem.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

In the absence of the President, Vice-President Don B. Weems, M.D., was in the chair at the January meeting of the *Gloucester County Medical Society,* which was held at the Woodbury Country Club on the 17th.

Louis K. Collins, M.D., chairman of the Public Relations Committee, read a letter from the state Public Relations Committee urging study and possible utilization of the plan of Atlantic County for around-the-clock medical service.

The scientific program was given by John T. Eads, M.D., assistant professor of Medicine at the Jefferson Medical College. "The Present Day Treatment of Peptic Ulcer and Outstanding Research on this Problem" was the topic and was excellently presented by Dr. Eads.

HUDSON COUNTY

John L. Varriano, M.D., Reporter

With Dr. Gleeson presiding, *Hudson County Medical Society* met at Murdoch Hall, Jersey City Medical Center, on January 8, 1952.

Dr. Ginsberg, chairman of the Committee on Postgraduate Medical Education, announced the completion of plans for the first illustrated course of postgraduate lectures covering clinical research and experiences in local hospitals to be sponsored by the Society. Dr. Angelo M. Gnassi and Dr. Carroll M. Leevy of the Departments of Medicine and Pathology, Jersey City Medical Center, will give the lectures on the subject of "The Diagnosis and Treatment of Liver Disease"—on five successive Friday afternoons at four o'clock, beginning on February 29, 1952. There will be no fee, and residents and interns at all local hospitals, as well as members of the Society, are invited to attend.

Elected to active membership were Dr. Earle W. Brauer of Jersey City, Dr. Arthur D. Hertzberg of Bayonne, and Dr. Raymond E. Pennie of North Bergen.

On the scientific program, guest lecturer was Dr. Morris Ziff, instructor in Medicine, New York University College of Medicine, who presented "Physiological Aspects of the Use of ACTH and Cortisone in Medical Practice".

HUNTERDON COUNTY

John B. Fuhrmann, M.D., Reporter

The regular meeting of the *Hunterdon County Medical Society* was held at Old Timbers Restaurant, January 22, 1952. Dr. John A. Flood, Jr., Lambertville, was elected to membership.

Recognition was given to the appointment of Dr. Ray Trussell as clinical professor of Preventive Medicine on the part-time staff of New York University-Bellevue Medical Center, New York.

President Bambara appointed a nominating committee to report at our annual meeting in March.

Dr. Harrold A. Murray, President-Elect of The Medical Society of New Jersey and Dr. Ray Trussell, Administrator of the Hunterdon Medical Center, discussed the formation of a County Health Department in Hunterdon County. Dr. Trussell presented the mechanics of the law and the advantages locally; while Dr. Murray gave us the viewpoint of the Medical Society and the advantages at a state level.

Following the meeting refreshments were enjoyed in conjunction with the Woman's Auxiliary, which met in another room of the building.

MIDDLESEX COUNTY

George M. Benko, M.D., Reporter

The January meeting of the *Middlesex County Medical Society* was held on January 16, 1952, at the Roosevelt Hospital, Metuchen. Dr. Charles H. Calvin, the newly elected president for 1952, brought the meeting to order promptly at 9:00 p.m. Dr. Raymond J. Gadek, the secretary, read a letter from the New Jersey State Employment Service, which stated that a Practical Nursing Service had been established by them to serve New Brunswick, South River and Jamesburg.

Dr. Paul R. Noble of New Brunswick was elected to Regular membership from Associate membership, and Dr. Gloria Stone Aiken of Bound Brook, was elected to a two-year period of Associate membership.

A suggestion was made by Dr. Charles Calvin urging newly elected members to attend meetings at or soon after their election so that they may be introduced to the members.

Dr. Sidney D. Becker, chairman of the Program Committee, stated that a man would be stationed at the parking area of the Roosevelt Hospital on the days of the postgraduate lectures, to direct the proper placement of autos. Dr. Becker also informed the members that a movie on the use of Wydase will be presented a half hour before the lecture and that it is intended to have a movie before each lecture. He also made note of the fact that members of the Society were speaking to various groups in a professional capacity without

properly notifying the Speaker's Bureau, headed by Cyril I. Hutner.

Under new business, Dr. Slobodien stated that one of the members requested information regarding the Medical-Surgical Plan type coverage for members of the Society. After discussion by those present a motion was passed designating Dr. Raymond Gadek to make a study of and report upon further details of this type of coverage to the chairman of the committee on Medical Liability and Insurance and, if possible, to have a representative of such an organization explain the features of the plan to the members.

Dr. Charles F. Church reported that 115 members or 52 per cent of the membership, answered the postcard survey on standard fees and upon statistical analysis of the reports, he calculated that the average fees for office visits were $3.00, for house calls $4.00, and for night calls $5.00.

Dr. Sidney D. Becker, of the Program Committee introduced DR. WILLIAM GRACE of Cornell University, the speaker of the evening, whose talk was entitled "Life Stress and Bodily Disease". Dr. Grace spoke enlighteningly of the correlations between stress situations and disease processes manifested by them in various systems of the body, particularly the gastro-intestinal tract. His lecture was generously illustrated with Kodachromes and charts gleaned from his wide and first-hand experience with this subject.

OCEAN COUNTY

Jesse Schulman, M.D., Reporter

The *Ocean County Medical Society* met on February 13, 1952, at Peterson's Sunset Cabin in Lakewood. The Scientific portion was devoted to an address by DR. ARTHUR E. BERNSTEIN of Newark's Beth Israel Hospital, who spoke on "Cardiac Emergencies".

The entire slate of officers was re-elected for the coming year as follows: DR. CARMEN L. PECORA, President; DR. RAYMOND A. TAYLOR, Vice-President; DR. ADOLPH TOWBIN, Treasurer; DR. RICHARD GOVE, Secretary; and DR. JESSE SCHULMAN, Reporter.

The Woman's Auxiliary, who were meeting at the same time, attended the scientific session.

The Society approved a request for the establishment of an eye clinic for indigent patients in Ocean County. A resolution was passed instructing the president to take steps to help improve the coroner service in the county. Plans for a joint meeting with the Ocean-Monmouth County Dental and Pharmaceutical Societies and the Monmouth County Medical Society were approved, as were plans for the Annual Ladies' Night and Installation of Officers to be held in March.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Woman's Club, Paterson, on January 15, 1952. SANDOR A. LEVINSOHN, M.D., president, presided at the meeting.

At the business session held prior to the scientific portion of the program, the following members were elected unanimously to the Board of Building Trustees to serve to May 1954: Drs. R. R. Goldenberg, Fred Vosburg, William Dwyer and S. J. Della Penna.

DR. SANFORD G. BLUESTEIN, Paterson, was elected to Associate membership.

A motion was passed to establish the dues for Courtesy membership at $20.00 a year, of which $10.00 will go to building maintenance.

Dr. Levinsohn announced that the February meeting will be held in our own building at 625 Broadway, Paterson, on Tuesday evening, the 19th. The Cancer Society is already occupying their office on the second floor and the Medical-Dental Service Bureau will be there shortly.

The Passaic County Medical Society extends an invitation to members and guests to attend an open house on Sunday, February 17, from 4:00 to 7:00 p. m.

Dr. Ianacone reported on the list of doctors for emergency service, emphasizing that this was a supplementary service and in no way intended to take over all emergency calls.

GEORGE F. CAHILL, M.D., director, Department of Urology, Squier Urologic Clinic, Presbyterian Hospital; professor of Urology, College of Physicians and Surgeons, Columbia University, spoke on "The Significance of Blood in the Urine", effectively illustrated with slides.

SOMERSET COUNTY

C. E. Case, Jr., M.D., Reporter

The regular monthly meeting of the *Somerset County Medical Society* was held on January 10, 1952, at the Somerset Hospital Nurses Home, DR. IRVING KLOMPUS presiding.

DR. WILLIAM O. WUESTER, Chief at the Green Memorial Cancer Clinic of the Elizabeth General Hospital, gave an exceedingly interesting and informative lecture on "Cancer of the Head and Neck".

Among matters openly discussed were the following: A program of dental health for the local schools, sponsored by the Plainfield Dental Society; provisions in the by-laws of the Somerset County Medical Society for the establishment of a *Judicial Committee* (motion carried); subscription, as individual beneficiaries, of the members of the Society in the New Jersey Blue Cross and Blue Shield plans; supplies made available by the American Cancer Society to indigent victims of cancer; the establishment of a county chapter of the American Heart Association (motion defeated).

N. J. DIABETES ASSOCIATION

E. O. Bauman, M.D., Secretary

Dr. Joseph Skwirsky was unanimously elected president of the New Jersey Diabetes Association at the Annual Meeting held in Newark on January 16, 1952. Dr. George Ginsburg of Hoboken was named as Vice-president and Dr. Otto Brandman of Newark as treasurer. Dr. Everett O. Bauman was elected secretary. A membership drive was authorized and publication of an announcement to that effect will be requested of the JOURNAL of The Medical Society of New Jersey.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

MRS. THOMAS H. McGLADE, West Collingswood

The Auxiliary Office facilities are constantly becoming more valuable to our officers, chairmen and members. The latest innovation is the master membership file. This file will contain the names, addresses and auxiliary data concerning every member in our organization. County auxiliaries should make every effort to send accurate and complete records of its membership. This will greatly increase the efficiency of our mailing procedure.

It is our desire to have our Auxiliary Office contain all the necessary reference material so essential to the work of the various committees. The archives and history chairmen have already compiled past records. The annual report booklets which give an excellent picture of the state and county yearly achievements are filed. We should like to establish a library of the Bulletin Magazine as an authentic background of auxiliary progress. It would be helpful in this work, if the members would send to the auxiliary office, any volumes from former years. A similar pattern at a county level would be equally helpful. In many instances, our records have much to be desired.

Our goal is to make every member an informed, alert and active member. Plan now to learn more about the auxiliary activities by attending the Convention, in Atlantic City, on May 19, 20 and 21.

AUXILIARY REPORTS

Bergen County

Mrs. W. H. Johnson,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Bergen County Medical Society* held its regular meeting on January 8, 1952, at Bergen Pines Hospital. The President, Mrs. Thomas Garrett, conducted the business meeting, receiving reports from all officers and chairmen of committees. Of special interest, the plans for the annual fashion show and dessert bridge, under the direction of Mrs. Thomas DeCecio, were announced. This party, which is the club's one big money-raising event of the year to augment its philanthropic fund, will be held on April 1, in the afternoon, at the Hackensack Woman's Club. The chief prize to be awarded this year will be a television set. The group hopes that the success of its bridge party this year will make it possible to launch a nursing scholarship program in Bergen County.

The next meeting will be a Valentine tea, to be held at the Englewood Hospital Lounge at 2 p. m., on February 12.

Following these announcements, the speaker of the evening, Mr. Daniel Belmont, of the U. S. Treasury Department, was introduced. He gave a very illuminating talk on "Narcotics, Their Effect on the Community, and How It Can Concern a Medical Auxiliary".

Burlington County

Mrs. Anthony V. Ziccardi,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Burlington County Medical Society* celebrated their 25th Anniversary at the Community House in Burlington on February 13, 1952. They entertained their husbands on this occasion with a special program and a buffet supper. The hostesses were: Mrs. W. Fred Lucas, Mrs. Bernard Leonard, Mrs. Abraham B. Sand, and Mrs. Paul R. Sparks.

Camden County

Mrs. Leland M. Stetser,
Chairman, Press and Publicity

A reception to honor new members was the highlight of the meeting of the *Woman's Auxiliary to the Camden County Medical Society*, which was held on February 5, 1952, at the Haddon Fortnightly, Haddonfield. Mrs. Francesco D'Imperio, Membership chairman, introduced the new members to the group. Mrs. Harold F. Westcott, President, conducted the meeting and called on Mrs.

Thomas H. McGlade, President of the State Auxiliary, to present the past presidents.

Mrs. Banks S. Baker, chairman of the Public Relations Committee, announced in her report that the annual Public Relations meeting is scheduled for March 25 at the Haddon Fortnightly from 10 a. m. to 3 p. m.

Following the business meeting, Mrs. Florian Nelles Douglass of Haddonfield, well known concert soprano, rendered musical selections, after which tea was served by the Hospitality committee.

Essex County

Mrs. Louis L. Covino,
Chairman, Press and Publicity

The January meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held at the Academy of Medicine, Newark, on Monday the 28th. Mrs. John Torppey presided. Following the business meeting, Mrs. Stuart Z. Hawkes, Program chairman, introduced Mr. Robert Parker, the guest speaker. Mr. Parker, former head of the Associated Press in Europe and War Correspondent, gave an interesting talk on World Events. He is also the author of two fascinating spy novels —"Ticket to Oblivion" and "Passport to Peril". His third book is due for publication this month.

Tea was served by Mrs. Otto Matheke, Jr., and her Hospitality committee.

On February 14, our Nurse Scholarship committee met with all the Directors of Nurse Training Schools in Essex County, to interview prospective student nurses for our Scholarship Award. Eight were interviewed and four of these were selected for further investigation. Present from the Auxiliary were Mrs. George Scheller, chairman, Mrs. John Torppey, Mrs. Pascal Baiocchi, Mrs. Otto Matheke, Jr., and Mrs. Jesse Glazier.

The Blood Bank Program at City Hospital is still in operation but needs more volunteers. Mrs. I. Borsher, chairman, needs your support in this important project. It requires only one hour, once a month to interview prospective donors at the hospital.

Gloucester County

Mrs. Chester I. Ulmer, Publicity Chairman

The annual husband's party was given by the *Woman's Auxiliary to the Gloucester County Medical Society* on January 24, 1952, at the home of Dr. and Mrs. Joseph F. Hughes in Woodbury. These get-togethers have always proved to be a huge success over the years and have contributed much to maintain the fine fellowship evident in our county among the members of the medical profession and their wives.

Those present were entertained with the showing of beautiful colored pictures taken on a recent Mediterranean cruise by Dr. and Mrs. Henry L. Sinexon and Dr. and Mrs. William W. Pedrick. Dr. Sinexon was the narrator. A bountiful buffet supper was served. The members of the committee were Mrs. Joseph F. Hughes, chairman; Mrs. George R. Booth, Mrs. Francis M. Brower, Mrs. R. S. Hughes, Mrs. John Laurusonis, Mrs. Baxter A. Livengood, Mrs. William W. Pedrick, Mrs. Henry L. Sinexon and Mrs. Chester I. Ulmer.

Hudson County

Mrs. Sydney Chayes, Chairman of Publicity

The *Woman's Auxiliary to The Hudson County Medical Society* met at Murdoch Hall, Jersey City, on February 4, 1952. Mrs. Morris Bresev presided and welcomed Mrs. Joseph Lally, a new member. Mrs. Irving Dershewitz, Program chairman, introduced Mrs. Helen Metzler who gave a resume of the popular Broadway productions: "The King and I", "Don Juan in Hell" and "Point of No Return". Refreshments preceded the meeting with Mrs. Joseph Giannasio and Mrs. Michael Cerchio as hostesses.

Mercer County

Mrs. Raymond Miller,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Mercer County Medical Society,* and the Mercer County Chapter of the American Cancer Society sponsored a fifteen-minute color movie entitled "Self-Detection of Breast Cancer", on Thursday, January 31, 1952, at Gimbel's Department Store, Trenton. Under the direction of Mrs. J. F. Johnson, chairman of the Health committee of the Auxiliary, this film was shown at 1, 3, 5, 6, 7 and 8 o'clock. Doctors were present after the showings of the movie to conduct fifteen minute question and answer periods.

Publicity for the American Cancer Society was handled by Mrs. Bernard Alexander, chairman; and for the Auxiliary, by Mrs. Raymond Miller, chairman, and Mrs. Bertram M. Bernstein, co-chairman.

Monmouth County

Mrs. Donald Bowne,
Chairman, Press and Publicity

The Woman's Auxiliary to the Monmouth County Medical Society held a meeting January 22, 1952, at Paul's Edgewaters, Wanamassa. Following the luncheon an interesting speech was delivered by Miss Joan Ann Chilton, interior decorator. Mrs. Edward Keleman was hostess for the meeting. On February 6, over Radio Station WJLK, the Auxiliary was represented by Mrs. Victor Siegel, president, and Mrs. John L. Ayers, Jr., on the Peggy Curtis Hour. Their subject, "Poisons in the Home", was an accident-prevention message. The Auxiliary is once more assisting in the distribution of Hearts for the National Heart Association Drive; Mrs. Richard Demaree is chairman and Mrs. Douglas Payne is co-chairman.

BOOK REVIEWS

Peptic Ulcer — Clinical Aspects, Diagnosis, and Management. Editor, David J. Sandweiss, M.D. 790 pages with 164 figures. Philadelphia, W. B. Saunders Company, 1951. ($15.00)

In the past six months two volumes have appeared in medical literature on peptic ulcer: one, edited by Dr. Ivy, and this one edited by Dr. Sandweiss. This reflects the importance of this disease and its invasion of our present day living. One would be tempted to compare these two books (both on the same subject) since it is difficult for either to say much that is different or to add very much that is new. However, in deference to the present work, we shall discuss it alone.

The first section deals with the anatomy and physiology of the upper gastro-intestinal tract. Of interest in this section is a chapter on applied anatomy of the esophagus and of the stomach. The second section deals with the etiology of peptic ulcer. We may summarize this chapter by quoting directly from a portion of the summary:

> "Many of the etiologic factors in both the experimentally produced peptic ulceration and the lesion in the human remain to be discovered."

Section Three deals with diagnosis and Section Four with medical treatment of uncomplicated gastroduodenal ulcer. Dr. Sandweiss does not endorse the use of enterogastrone or any other hormone, as a treatment of choice. It is regrettable that the chapter on the role of psychotherapy should be only five pages long.

Section Five deals with the surgical treatment of gastroduodenal ulcer. There is then a short section on peptic ulcer in infants and in the aged. Section Seven deals with esophageal ulcer, gastrojejunal ulcer, gastro-ileal ulcer, gastrojejunocolic fistula and Meckel's diverticulum.

The book closes with a section on complications of peptic ulcer, including electrolyte disturbances and perforated walled-off gastroduodenal ulcer.

The book is beautifully compiled. Under one cover are contained the opinions of 77 authorities. Naturally, little new is to be found in a book on a subject so extensively written upon and so widely discussed. At the same time, it is a noble contribution of the American Gastro-enterological Association.

Andrew J. V. Klein, M.D.

Clinical Allergy. By Samuel J. Taub, M.D. 2d Ed. Pp. 276. New York, Paul B. Hoeber, Inc., 1951.

This excellent volume states clearly and succinctly the current status of clinical allergy. It is written in a scientific, yet lucid style, and the material is presented in logical sequence. The first three chapters present the historical, physiologic and immunologic bases of the antigen-antibody relationships. The terms antigen, antibody, hapten, Forsmann antibody, reverse passive transfer, *et al.*, are briefly and clearly defined so that later in the book no confusion of terms will arise.

There then follows a consideration of the various allergic disease entities: hayfever, asthma, skin allergy, drug allergy, serum sickness, gastrointestinal allergy and miscellaneous allergic states, with complete discussions of the etiology, diagnostic procedures, role and relative importance of allergy, differential diagnosis, and therapy. One of the outstanding features of this book is the emphasis placed on differential diagnosis. Dr. Taub carefully outlines other diseases, such as sinusitis and mechanical irritants as the cause of sneezing and rhinorrhea and various cardiac and pulmonary conditions as a cause of wheezing.

Skin testing and desensitization therapy is clearly described, and their value in each type of allergy is stressed.

This book was written for the practicing physician with a serious interest in allergic problems. It lacks a bibliography and contains little academic or theoretical material. It is praiseworthy for its clarity, comprehensibility, and for its sensible assignment of allergy to the field of internal medicine.

Rowland D. Goodman, 2nd, M.D.

Rosenau Preventive Medicine and Hygiene. By Kenneth F. Maxcy, M.D., Dr. P.H. 7th ed. Pp. 1462. New York, Appleton-Century-Crofts, Inc., 1951. ($14.00)

This latest edition will become the "bible" and ready reference in hygiene and sanitation for the up-to-date physician in private practice and the student of medicine, as well as the public health worker.

The first edition in 1913 by Dr. Milton J. Rosenau (then Professor of Preventive Medicine and Hygiene at the Harvard Medical School) was revised five times by him. His sixth and last edition was published in 1935. This era was marked as the rapidly expanding and definitive period in preventive medicine and public health as a recognized specialty.

The information in the 7th edition (undertaken by Dr. Kenneth F. Maxcy, Professor of Epidemiology, The Johns Hopkins University, begun in 1942, under World War II handicaps), will assist every medical practitioner and health worker to render efficient service to citizens who comprise local communities, states and nations. Dr. Maxcy defines the responsibilities of private practice in relation to those of public health. The author emphasizes the importance of screening diagnoses in case finding and health education as functions for public health workers. Final diagnosis, treatment and reporting are responsibilities of private physicians. Both private medicine and public health have responsibility for tabulating and interpreting the resulting statistics and for developing community health programs accordingly.

The rich historical statistical tables justify public health and show progress in modern preventive treatment by adequately trained physicians. For example, the table "Smallpox in the United States, 1900-1949", demonstrates the victory in control of

that disease by preventive vaccination as "logical, specific, sensible and satisfactory".

In the nine sections of material carefully classified and catalogued into 51 headings, the author has made available up-to-date information gleaned from the older editions as collaborated by a long list of 25 highly qualified colleagues, each a specialist in a specific area of broad public health and medical subjects.

The author has attained the objective of a book affording a general orientation in the field of public health with all of its specialties. He has given particular attention to revision and addition of references, giving preference to review articles containing extensive bibliographies. Readers are enabled to pursue the subject in the literature if especially interested. Another attainment is the documentation of recent work that enables the reader to pick up the thread of current investigation.

Material on atomic energy is included. The author describes the source and nature of atomic particles and ionizing radiations, the structure of the atom, radioactive isotopes with definitions of units of measure and other terms currently used in the field of atomic energy. He gives an enlightening description of the effects of atomic radiation on the body. Dr. Maxcy points up the dangers of over-exposure, lists known standards of tolerance and states some problems in control of industrial wastes containing radiologic substances. Full appreciation of this one treatise requires careful reading. Knowledge contained here is essential to every private physician and public health worker, especially those who have responsibility for civil defense organization and functions.

Other chapters on subjects of increasing interest in preventive public health are those devoted to noise, the effects of high and low barometric pressures, atmospheric pollution, occupational diseases, chemical exposures, dust, gases and organic compounds and water and its relation to disease.

Since an ever increasing responsibility for community health rests on private practitioners, this book is especially recommended as a reference work for these physicians.

G. F. MOENCH, M.D., M.P.H.

Physicians' Desk Reference to Pharmaceutical Specialties. Ed. 6. Medical Economics, Inc., Rutherford, N. J., 1952. (Pp. 301)

New Jersey's annual contribution to the busy practitioner once again makes its appearance. The 1952 edition follows the general format which has proved its usefulness in the past. Drugs introduced since December 1950 are added to the older listings. There is a new catalogue of pictures, charts, films, brochures and booklets which may be obtained gratis from the various pharmaceutical companies. The "Professional Information Section" has been expanded and now includes ready-reference tables of dosages, antidotes, height and weight, normal blood, urine and spinal fluid findings, metric and thermometric conversion tables, drug incompatibilities, hints on removing medical stains, blood typing and blood grouping information, infant feeding formulae, food-calorie values and lists of common household substances with notes as to their possibly toxic ingredients.

The backbone of P.D.R. of course is the registry of drugs and biologicals. More than five thousand products are listed, and once you have learned to use the book, you can find in a few seconds the trade name, the manufacturer, the recommended dose, the method of administration and how it is packed and marketed. There is even included a roster of pharmaceutical houses with their emergency telephone numbers if you ever have to obtain some obscure drug in a hurry. Drugs are listed three ways: by name of manufacturer, alphabetically by name of product, and therapeutically according to the indication for the use of the drug. The book is distributed gratis and will earn its desk space on its first day of use.

WILLIAM SCHRAM, M.D.

Penicillin Decade. By Lawrence W. Smith, M.D., and Ann Dolan Walker, R.N. Arundel Press, Washington 13, D. C. Pp. 122, 1952. ($2.50)

In 122 pages, these authors manage to pack in 342 references reflecting reports of toxic effects of, or sensitivity to penicillin and its carriers. The senior author is medical director of the Commercial Solvents Corporation which, through its pharmaceutical division, makes and distributes several varieties of penicillin. Under the circumstances, this honest account of the dangers of penicillin is a tribute to the integrity of the authors and of their company. They cite evidence showing that staphylococci, at least are manifesting a steadily increasing resistance to this drug. "One shudders to contemplate", write the authors, "the clinical significance of this increasing resistance in another decade". They warn that antibiotics are of value only in the treatment of infections due to organisms sensitive to them. They suggest ways of desensitizing and detoxifying to the end that the untoward reactions may be eliminated. All in all, the book is a thorough job of studying the undesirable effects of ill-considered penicillin administration.

VICTOR HUBERMAN, M.D.

Something Can Be Done About Chronic Illness. Herbert Yahraes. Public Affairs Pamphlet No. 176. Pp. 23. New York, 1952. (25c)

A program for dealing with America's No. 1 health problem — chronic disease — is outlined in *Something Can Be Done About Chronic Illness*, a popular 25-cent pamphlet published by the National Commission on Chronic Illness and the Public Affairs Committee.

Introducing the pamphlet, Dr. Leonard W. Mayo, chairman of the Commission on Chronic Illness, declares that "the problem can be solved only with the full cooperation of the medical profession and the public health and welfare officials working together. . . . Its solution is dependent not only on the professions, but on the community leadership that in this country is responsible for producing such medical care facilities as hospitals, diagnostic centers, and home care programs".

Although the amount of chronic illness has in-

creased in recent years as the proportion of older folks in the population has increased, the over-all picture is described as an encouraging one.

Unfortunately, advances that have been made in preventing, ameliorating, or postponing the effects of chronic disease have, the pamphlet admits, far outstripped any progress in preventing these diseases from developing. What is primarily needed in this area, are means for detecting the disease early—"of bringing the disease to the doctor before it brings you".

This would be no problem, it adds, "if everyone in the United States could or would go to his physician for a complete health inventory once or twice a year".

Ulysses Frank, M.D.

The Battle for Mental Health. James Clark Moloney, M.D. New York, The Philosophical Library, Pp. 105, 1952. ($3.50)

Although apparently a text-book on psychiatry, this is actually directed at mothers, obstetricians and pediatricians. The author's thesis is that emotional illness is due primarily to our regimented, authoritarian, guilt-producing methods of child rearing. He thinks that most of the women in this country are "passively dependent", arguing indeed that there are more such women than there are "normal" women. (Which leads to the startling conclusion that the average woman is not normal!) The women then transmit this dependency-feeling to their children who develop the idea that there is danger in being independent or adventurous, hence they become neurotically dependent when they grow up. As a result the world is in a mess. The author is a well known psycho-analyst as well as an experienced writer and he presents his thesis with vigor and clarity.

Herbert Boehm, M.D.

Your Diabetes. Herbert Pollack, M.D., and Mary V. Krause, M.S. Pp. 212. New York, Paul B. Hoeber, Inc. 1952. ($3.00)

After an interesting review of the history of diabetes, the authors explain present concept of diabetes, the action of different forms of insulin and their indications. There are practical hints for patients, such as how to examine urine specimens, how to handle insulin while traveling, et cetera. A chapter is devoted to the problems of the young diabetic. Pregnancy, surgical complications and coma are dealt with in a clear and concise manner. Emphasis is place upon hygiene of the extremities. Mary Krause, consulting dietician at Mt. Sinai Hospital, discusses the diabetic diet and offers a valuable list of sample meals including recipes for special dishes. The last chapter is "Questions and Answers", the questions being those most frequently asked by the patient.

The manual, written in a breezy and simple manner, will prove of value. An intelligent patient who understands his diabetes and the problems involved is always a better patient.

Otto Brandman, M.D.

Backache, Birth and Figure Relief by Self-Revolving Hipbones. By W. Schoenau. Pp. 264. Los Angeles, Wm. Schoenau, 1951. ($2.00)

Dear Ed.:

Herewith results of my investigations re: above book: Self-revolved left hip forward, ischium forward, and hip joint back on sacrum (v. pp. 13-14), ended up with legs in bowline knot. Self-revolved both hips in opposite directions (p. 15), now undecided whether am walking forward or backward. Tried to sit with 51 per cent of weight on painful buttock, best I could get was 50.7 per cent. Tried revolving hip joints in traffic, ruined right rear fender. Revolved hip joint back while dancing, was bounced from dance hall for indecent behavior. Self-revolved self out of bed, now wife won't talk to me. Tried lying back with legs straight in air while in hospital one day was approached by two gynecologists and one proctologist! Learned that pinching spinal cord may cause death, now fear to go near my secretary.

Read chapter on birth eased by self-revolving hipbones, but still unable to become pregnant. Tried enlarging inlet 5 per cent or outlet 25 per cent, again no success.

Curious about author, wrote for autobiography. Found he is a lawyer, born July 9, 1894, Buffalo, N. Y. States, "The special qualifications that I have result from my experience with my own sacroiliac joints and on extensive study of the ways mechanical pressures affect the pelvis of a human skeleton. The first ten years after injuring my back while lifting I grew worse in spite of trying the methods of many books and professional people. After learning how to control my own sacroiliac joints I spent all of my time for about four years writing and re-writing the book."

Yr. obed. serv.,

Sir John Straightchilde, M.B.

Dynamic Psychiatry: Basic Principles. Louis S. London, M.D. Pp. 98. 1952. Corinthian Publications, Inc., New York. ($2.00)

Apparently this is intended to be the first of several volumes dealing with dynamic psychiatry. Half of the current book is devoted to a historical review of psychiatry which, though interesting, has no practical value in daily office or hospital practice. The rest of the volume is made up of chapters analyzing the libido according to various schools of thought. The book is useful for beginning students in psychiatry and morbid psychology. It will also be helpful to the psychiatrist who wants source material for preparing a lecture or course of lectures to advanced students.

Dr. London is well recognized among psychiatrists as a profound student of the libido. The sections dealing with this reflect his mastery of that subspeciality of psychiatry. However, there is, in this book, no description of any treatment methods.

Abraham Leff, M.D.

TUBERCULOSIS

ABSTRACTS

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV March, 1952 No. 3

MASS ROENTGENOGRAPHIC SURVEYS IN SMALL HOSPITALS

Russell H. Morgan, M.D., The American Review of Tuberculosis, September, 1951.

When mass roentgenographic procedures were applied to the tuberculosis case-finding program a few years ago, it was soon realized that the patients admitted to general hospitals constituted a large and readily accessible group in which the yield of positive cases was considerably greater than that occurring in mass surveys of other groups. Hodges demonstrated that the incidence of tuberculosis among the patients admitted to the University of Michigan Hospital was 2.3 per cent. Moreover, the detection of other pathology brought the total yield of significant lesions to almost 10 per cent.

There has been a rather slow acceptance of mass roentgenographic procedures among hospitals having capacities of 50 to 250 beds. This has been due, in part, to the understandable reluctance of attending radiologists to undertake a burden of some magnitude without a reasonable return. In the larger teaching hospitals many of the radiologists have provided routine small-film examinations at no cost to the patient—a policy which has caused some health authorities to advocate free routine chest examinations in all hospitals. This thinking, however, is not necessarily sound when applied to small hospitals.

In many small hospitals, funds are not available to furnish a mass photofluorographic installation from operating revenues and the radiologist may provide the necessary equipment. If this is the case, free routine admission chest films can hardly be insisted upon. Ten to twelve thousand dollars will be required for the installation and a charge of about $1.50 per chest film will be necessary. This charge for a minature chest film is a reasonable levy. The frequent detection of unsuspected pathology makes them worth many times their cost to the persons with pulmonary lesions. Thus, where public funds are not available to install a routine chest unit in a small hospital, each patient should be charged a nominal sum for the unit's support. Indeed every local tuberculosis association should examine its budget to determine whether money is available to demonstrate the value of the procedure. Many times a little added support will make successful mass chest survey programs in small hospitals possible.

Another reason for the slow acceptance of routine photofluorographic examinations in small general hospitals has been the erroneous belief that these procedures become inefficient and costly when numbers less than fifty to one hundred are to be examined each day. To illustrate this point let us examine the situation in a large general hospital and then adapt it to a hospital having a capacity of 100 beds.

The technical cost of performing a photofluorographic examination may be divided into the following categories:

a) Amortization on capital equipment
b) Service to capital equipment
c) Photofluorographic supplies such as film and developer
d) Personnel, including technician, secretary, and such other persons as are necessary
e) Rental of floor space
f) Utilities, including light, heat, telephone, and laundry.

In a large hospital about 15,000 examinations are performed each year. The service charges usually average five cents per exposure or $750 for 15,000 examinations. These charges will be

incurred when X-ray tubes, valve tubes, or other components require replacement. The cost of photofluorographic film and other supplies for units using 70 mm. film also amounts to approximately seven cents per exposure or $1,050 for 15,000 examinations.

The personnel needs of a photofluorographic installation will vary. However, where the yearly number of examinations approaches 15,000 one X-ray technician and one clerk-typist are needed. These individuals register the patients, make and process the films, record reports from the radiologists who read the films, and file the films and reports. The floor space needed usually approaches 500 square feet. At a nominal rental such space represents an expense to the procedure of $1,500. Electric power and telephone service may approach $300.

The technical cost of operating a photofluorographic unit in a large general hospital may be:

1) Amortization of capital equipment	$ 1,500
2) Service charges	750
3) Film and developing chemicals	1,050
4) Personnel	5,100
5) Floor space	1,500
6) Utilities and miscellaneous expense	300
Total	$10,200

The technical cost per routine chest film in a large hospital approaches seventy cents.

Let us now examine a hospital with a capacity of 100 beds and 2,000 or more admissions per year or 8 admissions per day. In such a hospital an economical arrangement can be achieved usually by placing a photofluorographic hood and cut-film camera within a room of the department of radiology. The capital equipment, in a department of radiology today costs approximately $7,500. The regular case-load in a hospital of this size approaches 16 patients per day. Since the photofluorographic portion of this load constitutes one-third of the total, one-third of the cost of capital equipment (or $2,500) should be amortized against the routine chest procedures. To perform the photofluorographic examinations a hood and cut-film camera will be needed. Even in a small hospital, photofluorographic procedures are more economical. If all the equipment is amortized on a ten-year basis and 2,000 examinations were done each year the total equipment costs would be about 25 cents per film. The costs of service, film and developing chemicals, and personnel will approach $100, $140, and $700, respectively.

The technical budget for a small 100-bed hospital performing routine chest examinations might include:

Amortization of capital equipment at hand	$ 250
Amortization of photofluorographic apparatus	250
Service	100
Films and developing chemicals	140
Personnel	700
Floor space	500
Utilities and extras	50
	$1,990

If 2,000 examinations are performed within this budget, the technical cost per examination would be just under one dollar, which is only 50 per cent greater than that encountered in a large general hospital. This difference clearly indicates that from an economical standpoint mass chest surveys are feasible in small hospitals.

Nothing has been said regarding the professional fees of the radiologist who reads the routine chest films of a small hospital. It seems unreasonable that a physician who makes his living from radiological methods should forego revenue from so time-consuming a procedure. These charges, which usually approximate fifty cents per film, bring the total cost of the photofluorographic examination in a small hospital to approximately $1.50.

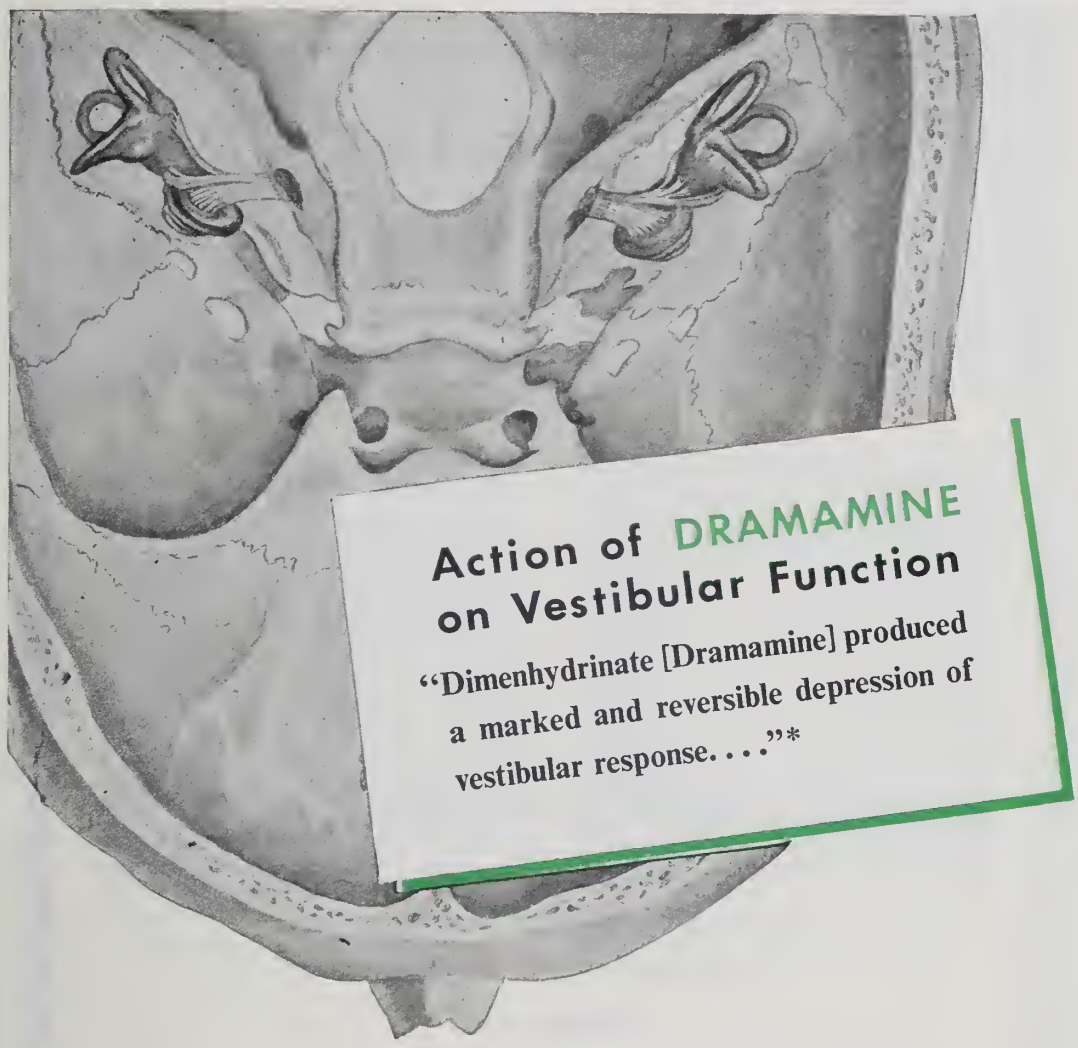
Most small hospitals should have mass radiographic equipment which could be used to serve the community as well as the hospitals.

In this abstract the author has changed some of the figures used in the original article in order to bring them more in line with the current situation.

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*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. *53*:308 (March) 1951.

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Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

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Meat and its Important Contribution of Essential Minerals

With the exception of calcium and iodine,[1] meat, as customarily consumed, makes an important contribution to the mineral needs of the American people. Its minerals include those needed in substantial amounts as well as those needed in trace amounts only.

The array of data listed below gives the approximate amounts of essential minerals provided by muscle meat when seven ounces per day are consumed.[1] The minerals include those now known to be essential components of the human organism—the skeletal framework and teeth, soft tissue structures including blood, and substances concerned in regulatory functions.

APPROXIMATE MINERAL CONTENT OF MEATS

200 Gm. (approx. 7 oz.),[1] Edible Portion (Uncooked)

	Beef Round	Lamb Leg	Pork Loin	Veal Shoulder
Minerals, total[2]	2.0 Gm.	1.8 Gm.	1.8 Gm.	2.0 Gm.
Calcium[2]	22 mg.	20 mg.	20 mg.	22 mg.
Chlorine[3]	147 mg.	136 mg.	125 mg.	147 mg.
Copper[3]	0.2 mg.	0.2 mg.	0.2 mg.	0.2 mg.
*Iodine[4] (Ohio animals)	0.02 mg.	0.03 mg.	Data not available	0.01 mg.
Iron[2]	5.8 mg.	5.4 mg.	5.0 mg.	5.8 mg.
Magnesium[3]	46 mg.	42 mg.	39 mg.	46 mg.
Phosphorus[2]	360 mg.	426 mg.	372 mg.	398 mg.
Potassium[3]	661 mg.	610 mg.	559 mg.	661 mg.
Sodium[3]	164 mg.	152 mg.	139 mg.	164 mg.
†Cobalt[5]	0.0002 mg.	———	Data not yet available	———
†Manganese[3]	0.03 mg.	0.03 mg.	0.02 mg.	0.03 mg.
†Zinc[5]	9.4 mg.	———	Data not yet available	———

*Iodine content of meat varies with the iodine content of feed of the animals.
†Needed in trace amounts only.

The average values for iron, phosphorus, and copper of the four kinds of meat shown constitute about 46, 25, and 100 per cent, respectively, of the National Research Council's recommended daily allowances for adults, and the average values for chlorine, potassium, and sodium constitute about 14, 63, and 16 per cent, respectively, of the estimated daily adult needs, as based on mineral balance studies.[6] Although no specific information is available on the quantitative needs for cobalt, magnesium, manganese, and zinc, nutrition information would suggest that the amounts reported above have nutritional importance or significance.

In addition to its notable content of essential minerals, meat also furnishes large amounts of biologically complete protein and important amounts of vitamin B complex, which includes biotin, choline, folic acid, inositol, niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and vitamin B_{12}. On the basis of its rich contribution of nutritional essentials, meat well deserves its prominent place in the daily diet of the American people, the world's best-nourished people.

1. Recent estimates of the U. S. Department of Agriculture indicate that the per capita consumption of meat in the United States approaches seven ounces per day.
2. Watt, B. K., and Merrill, A. L.: Composition of Foods —Raw, Processed, Prepared, In Agriculture Handbook No. 8, United States Department of Agriculture, 1950.
3. Estimated on basis of protein content of meats. Sherman, H. C.: Food Products, ed. 4, New York, The Macmillan Company, 1948, p. 155.
4. Ohio animals; varies with iodine content of feed. Johnson, H. J.: Bridges' Dietetics for the Clinician, ed. 5, Philadelphia, Lea & Febiger, 1949, p. 800.
5. Mitteldorf, A. J., and Landon, D. O.: Analytical Chemistry; Spectrochemical Analysis of Beef for Mineral-Element Content, Armour Research Foundation of Illinois Institute of Technology. In Press.
6. Dauphinee, J. A.: Sodium, Potassium, and Chloride Malnutrition, Including Water Balance and Shock, in Jolliffe, N.; Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, p. 341.

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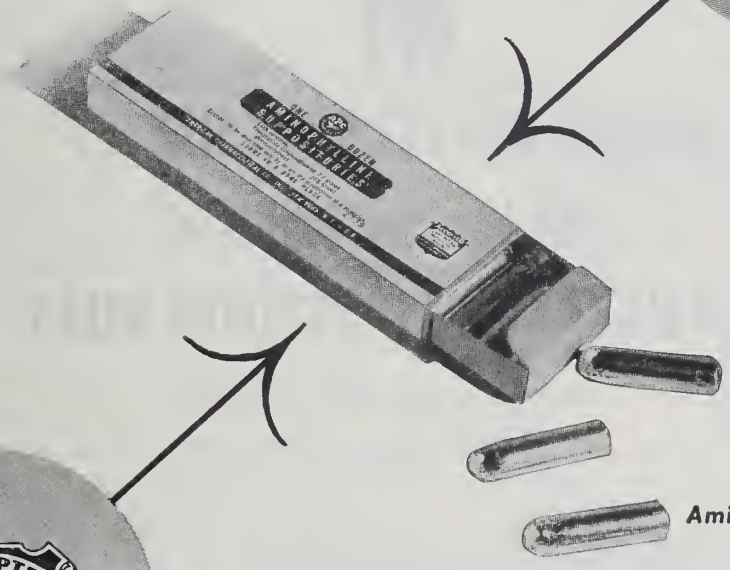
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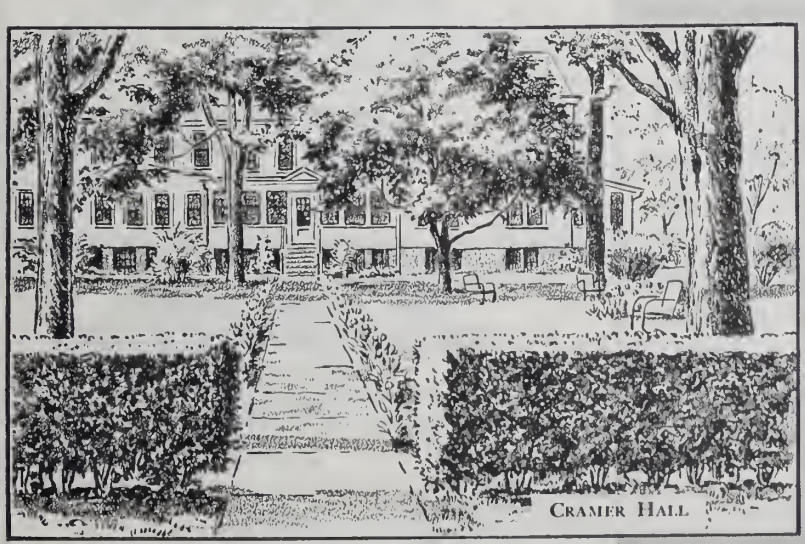
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GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

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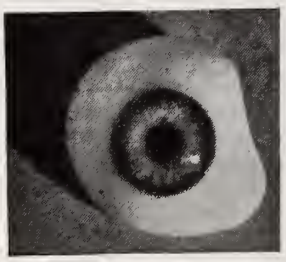
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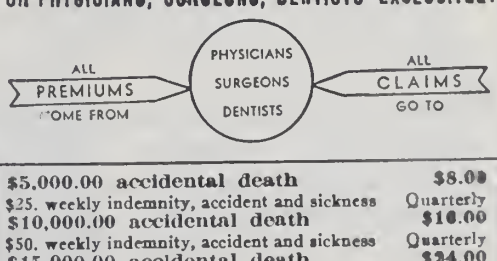
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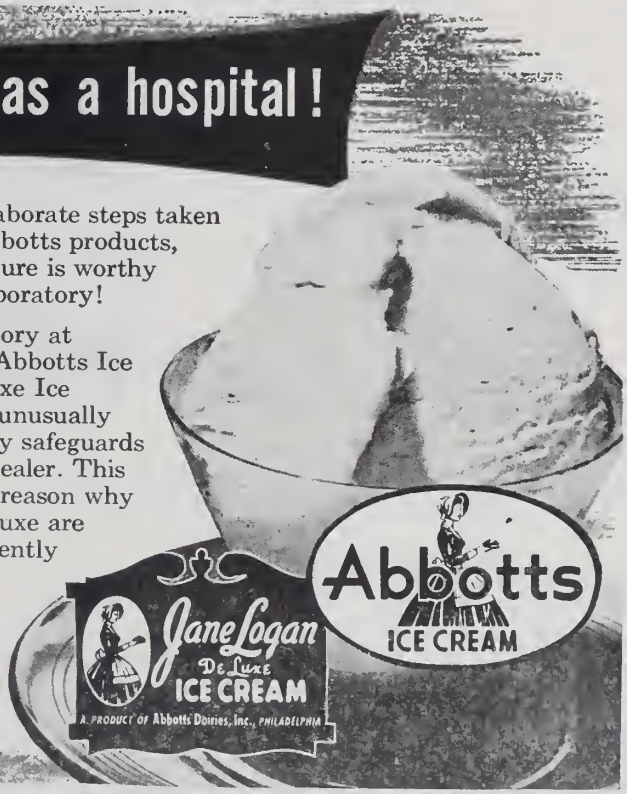
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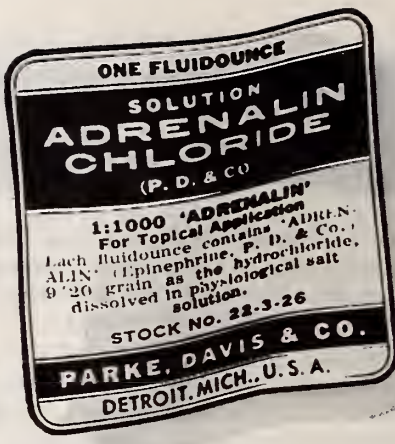
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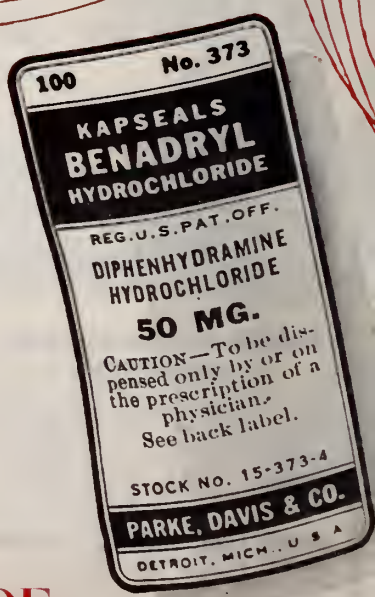


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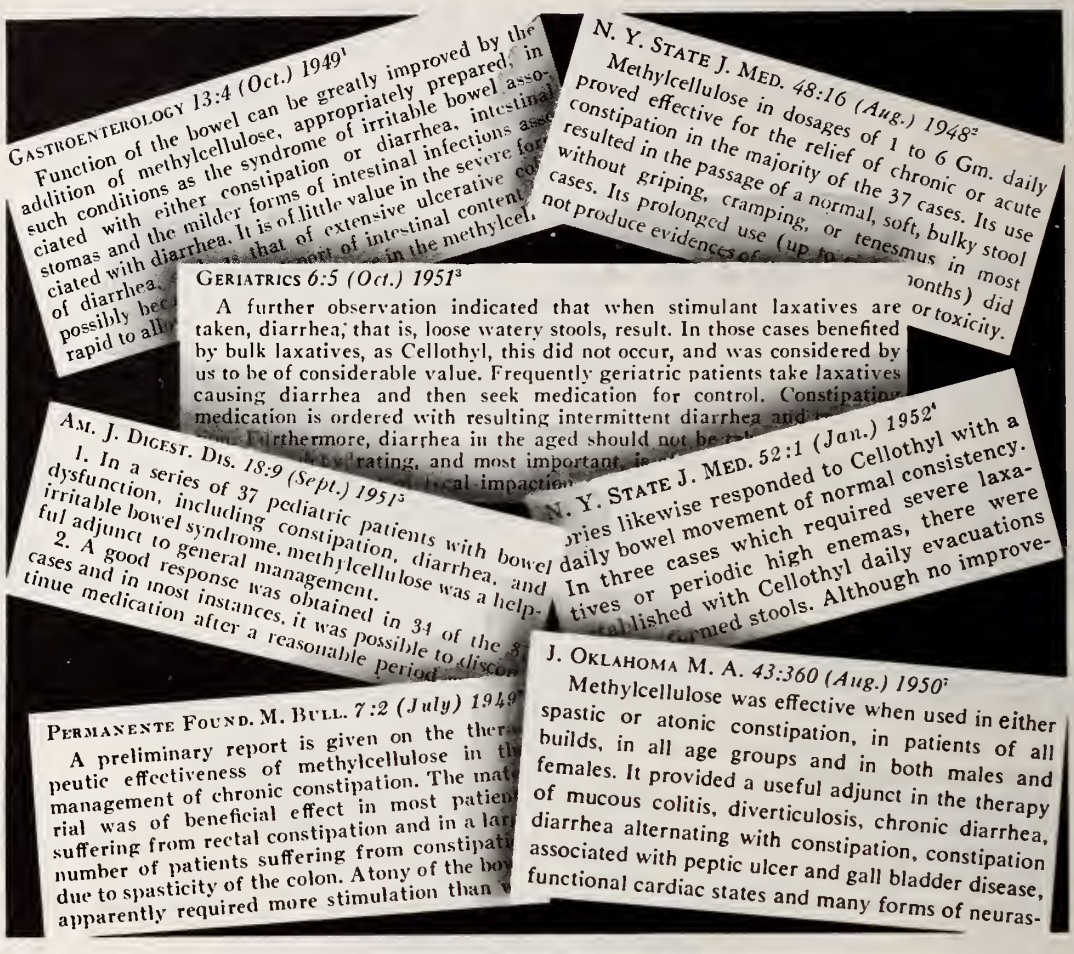
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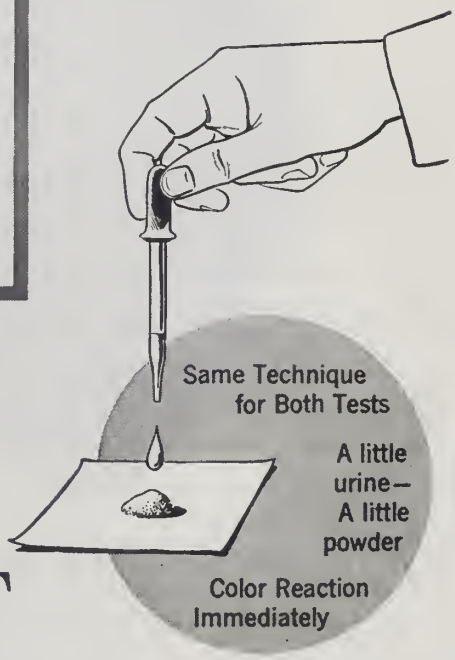
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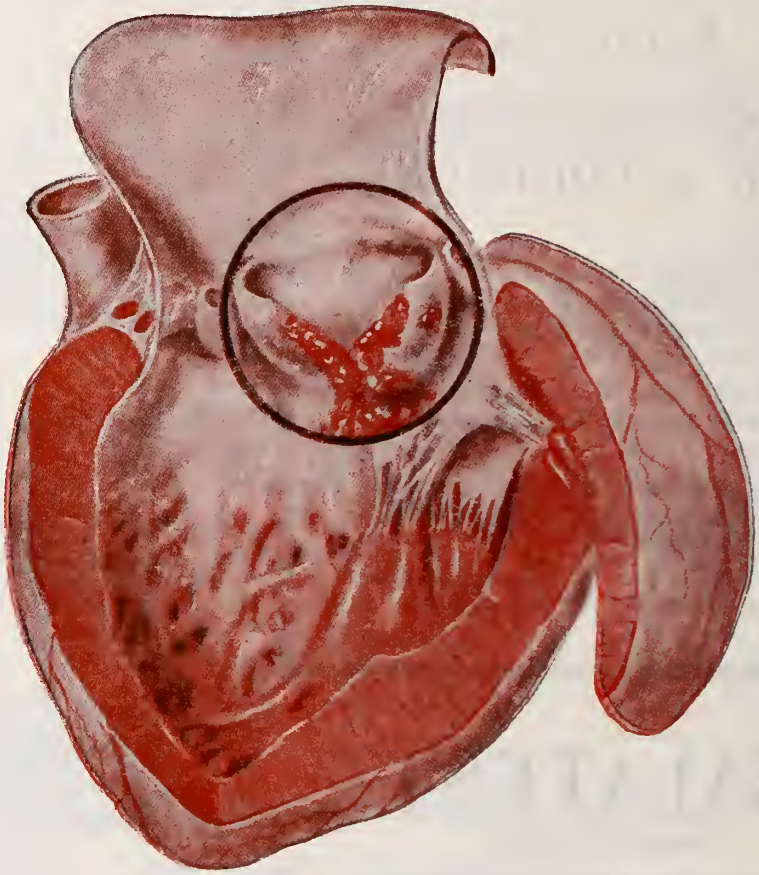
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"Cortisone and ACTH—A Review of Certain Physiologic Effects and Their Clinical Implications" — Randall G. Sprague, M.D.—American Journal of Medicine, May, 1951.



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Blake, F. G.; Friou, G. J., and Wagner, R.R.: Yale J. Biol. and Med. 22:495 (July) 1950.

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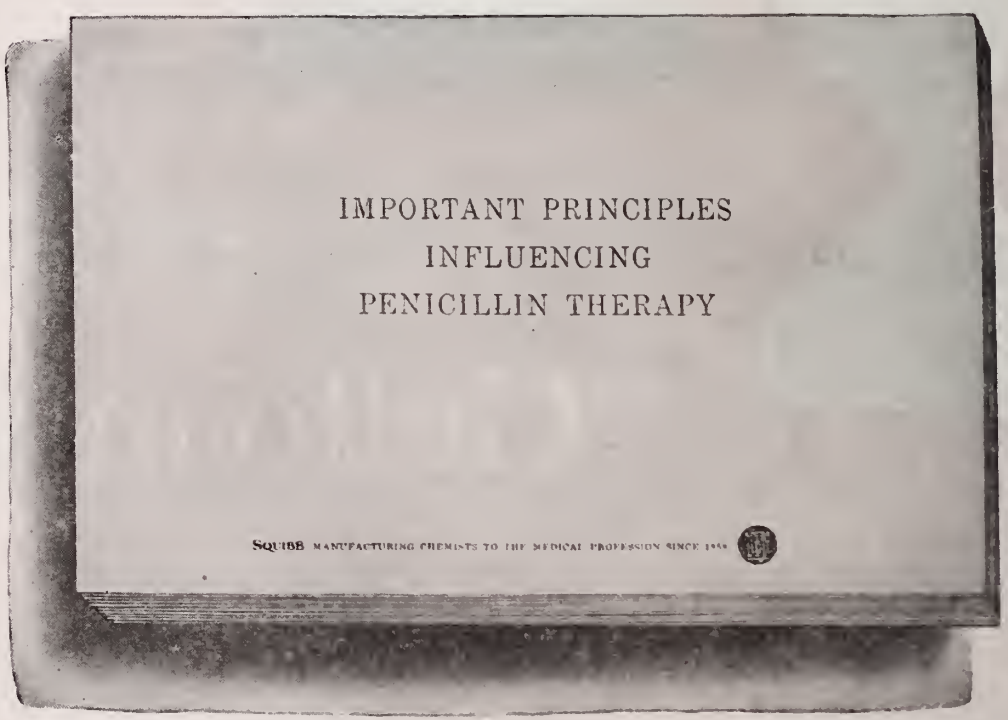
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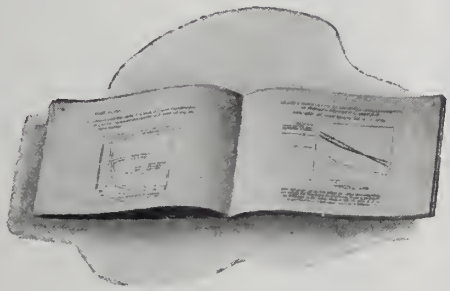
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Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

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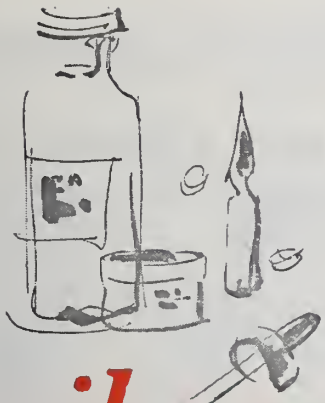
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1. Perloff, Wm. H., (1951) Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 2. Reich, W. J., et al. (1951), A Recent Advance in Estrogenic Therapy. I. American J. Obst. & Gynec., 62:427, August.

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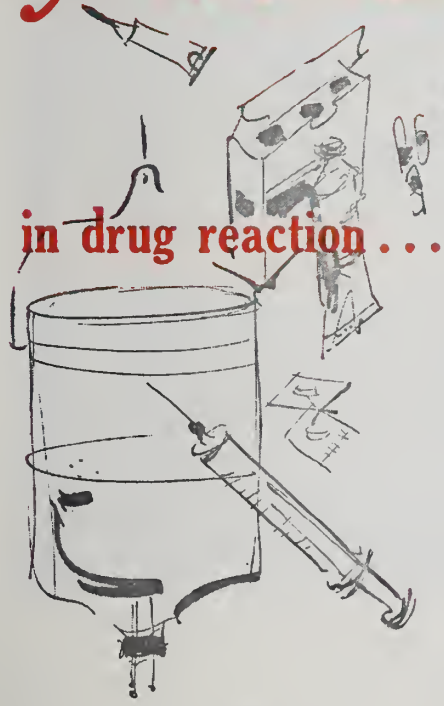
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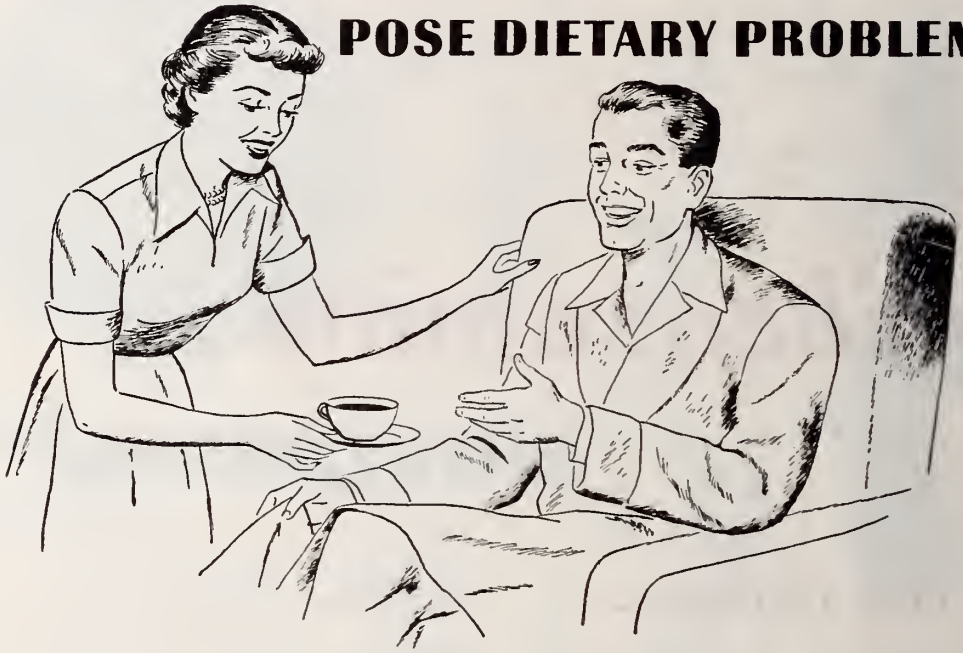
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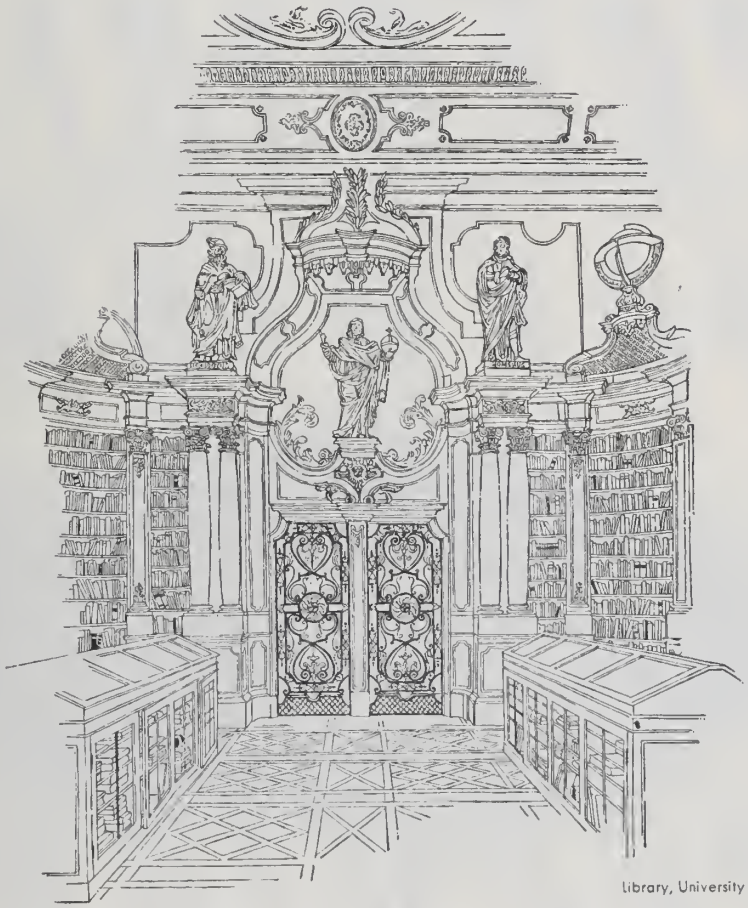
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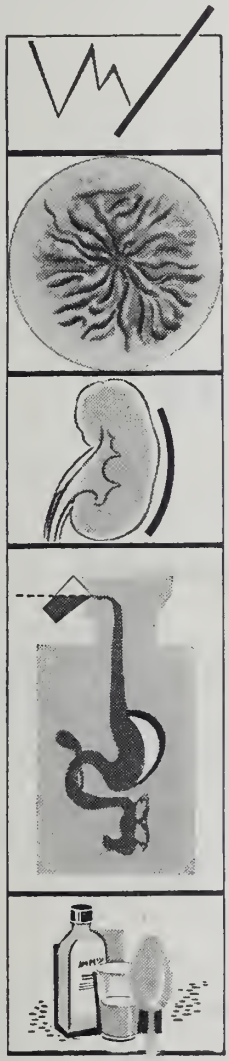
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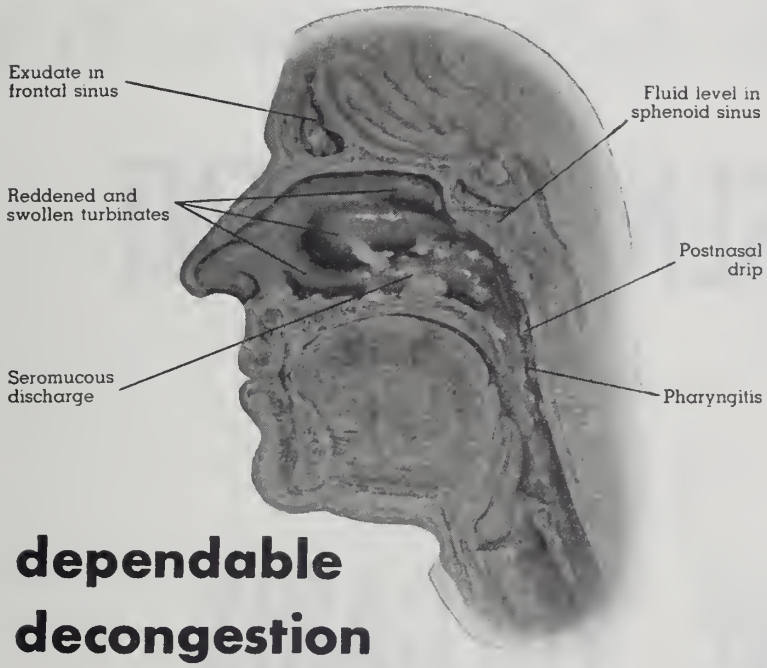
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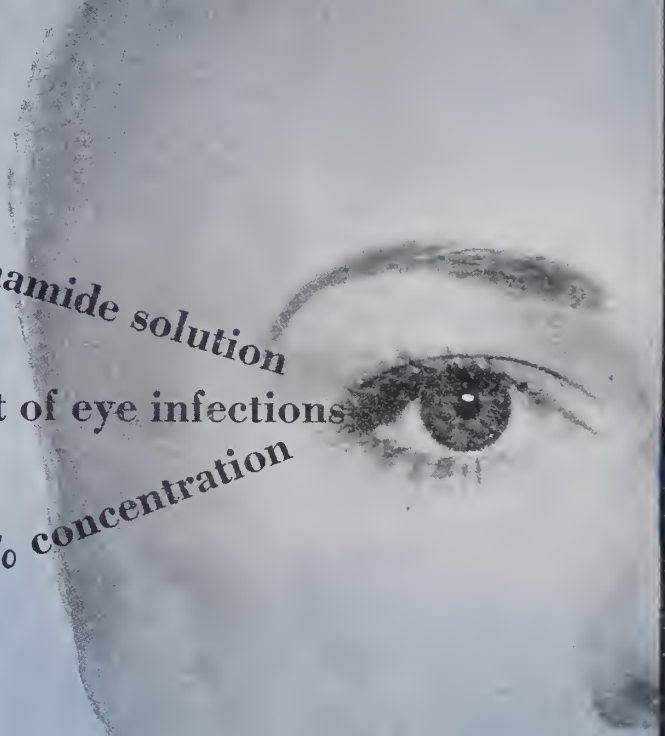
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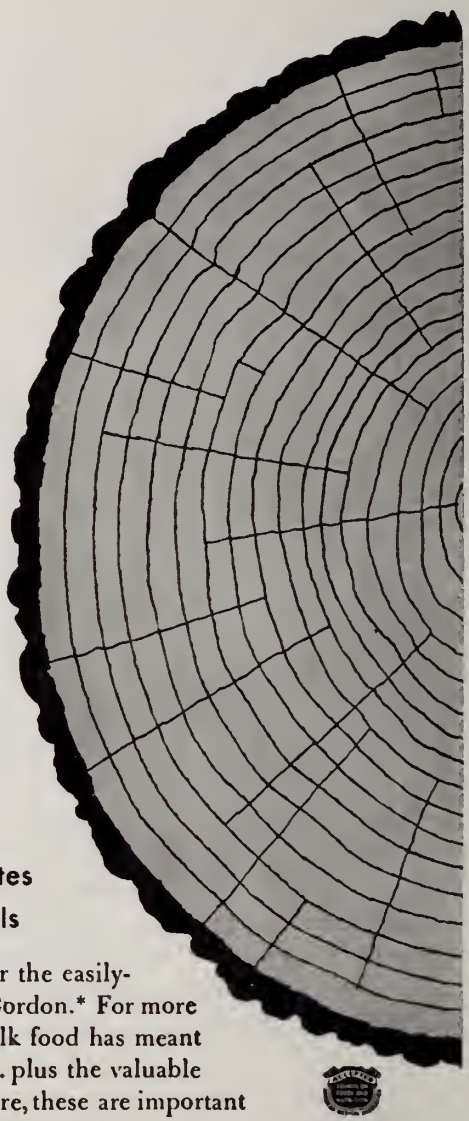
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*Gordon, Harry H.: Feeding of Premature Infants, American Journal of Diseases of Children 73:713 (June) 1947.

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PRESIDENT'S MESSAGE

It seems incredible that another year has run its course and that we are now looking forward to our One Hundred and Eighty-sixth Annual Meeting in Atlantic City.

The Program Committee has restored the Section meetings. The programs arranged by the Sections offer a varied and valuable postgraduate seminar. A wide choice of topics and speakers is being presented.

The General Session has been arranged so that the greatest number of people may have the privilege of hearing the addresses of our President-Elect, Dr. Harrold A. Murray, and of our Guest-Speaker, the Honorable Harry P. Cain, United States Senator from the great State of Washington. At what is probably the most crucial period of our nation's history, Senator Cain will bring us a serious and important message on "The Dangers We Face". Senator Cain, as you know, was instrumental in blocking the appointment of Mon Walgren as chairman of the National Security Resources Board. He was also responsible for securing the Senate Committee investigation of the dismissal of General MacArthur by President Truman. He is a Reserve Colonel in the Air Borne Troops and was a Colonel on active service with the 82d Air Borne Division of Paratroopers in World War II. He is a member of the powerful Armed Services Committee of the United States Senate. We are very fortunate in being honored with his presence. We are looking forward to a wonderful convention and urge you to send in your reservations at once, if you have not already done so.

I wish to take this opportunity of ex-

pressing my thanks to all of our members who have worked hard to prepare this program. I am sure this expression of thanks will be echoed by the sections and members who attend our annual meeting.

Your officers and staff have done everything possible to make this meeting worthwhile. Your presence and participation will be their best reward and the one reliable measure of the success of their efforts.

Sigurd W. Johnsen, M.D.

THE QUALITY OF SCIENTIFIC ARTICLES

Of the 1215 members who responded to the questionnaire last May, only 24 wanted fewer scientific articles. Many of the appended comments, however, indicated dissatisfaction with the caliber of the original articles published every month in this Journal. There were several comments to the effect that too many articles were repetitions of, or abstracts of, book material. It is easy to understand how this develops. A harassed program chairman calls on a member to prepare a paper. He reluctantly consents and his preparation starts with reviewing and abstracting the literature. At first he is modest about it but when he reads it, he warms up to the subject, and finally concludes, quite objectively, that it is a "pretty good" paper. He submits it to this Journal. We have, of course, a policy of favoring New Jersey authors. The paper was well received. While it did consist largely of summaries of the literature, the Publication Committee felt that there was practical value in such a summary. It spared other members from the chore of digesting the literature. It threw the subject into sharp focus.

Ideally, an author should not offer a paper if it represents nothing but a summary of the literature. His interest is usually aroused by a case of his own. This sends him to the literature for background. The paper then is not just a review of the literature; it is that plus a case report plus a filtering of the literature through this one author's experience. In general, this does make an acceptable paper. It is not as inspiring as a brand new medical discovery. But practicing clinicians do not make absolutely brand new discoveries more than once or twice a century.

Several members thought that we should reject any article not based on original work. However this is a gospel of perfection. The clinician has his work cut out for him diagnosing and treating sick people. This is his "work". His work is not with test-tubes, retorts or kymographs. To deny him an outlet for a critical review of the literature plus an original case report, is to suppress the kind of paper which is, after all, the basic building block of clinical medical progress. If a researcher shows with guinea pigs that a certain drug ought to relieve the symptoms of omphalmoma, this is interesting. But it does not become a real contribution to medical practice until some clinician tries it on an actual case omphalmoma. The job is a double one and no one can say that the clinician's work is more or less important than the job of the basic researcher. Neither would be useful without the other. The research man has his own scientific outlets. State medical journals are the essential outlets for the clinician. To scorn the brief clinical paper, with its meager supply of case reports and its frankly second-hand review of the literature is, we suspect, intellectual snobbery. The clinician may be only the junior half of the team, but he is an indispensable part of it.

A faint, but audible, murmur of protest was raised against the popularity of the "new drug" article. Typically this is set up as follows: a clinician is persuaded by a detail man or by a drug manufacturer—or by his own insight—to try a new synthetic drug for some common condition. He administers the drug to twenty or fifty or a hundred subjects and uses a placebo with a like number of controls. He then finds 72 per cent improvement in group A and 27 per cent improvement in group B and concludes that this new synthetic drug is helpful. The drug manufacturer buys up 50,000 reprints of the paper and distributes it widely. Now a statistician could quarrel with the conclusions. (He would ask whether the difference between 27 per cent and 72 per cent was beyond the range of "probable error".) So would the research department of a rival drug manufacturer. And often a few years later, the newly heralded drug has been consigned to the limbo either because a better preparation has been developed or because the original good results were found to be due to psychologic effect or because unsuspected side-effects rose to plague the patients.

All this is possible. However it does not derogate from the fact that "new drug" papers of this type are potentially valuable. Even if four out of five of them turn out, on later study, to have been over-optimistic, that fifth one will hit the therapeutic jack-pot. We think it good medical journalism to keep our pages open to studies of this sort. Even if only one paper in five—or only one in twenty—turns out to be permanently valuable, we will have a score to be proud of.

Some readers will not be satisfied with this explanation. Noble perfectionists, they want only top-notch papers to appear in our pages; papers which blaze new trails, report results only with iron-clad scientific proof. We all respect such aims, and ask only that these well-meaning critics submit papers which meet those splendid criteria.

IF YOUR PATIENT IS BEING INDUCTED—

The family doctor's carelessness about answering letters from the induction station has resulted in wastage of time, money and effort in obtaining supportive medical history; and may cause an occasional improper induction. At the Newark station, for example, it is necessary to send to private practitioners about 100 letters a month asking for the selectee's case history. About 83 of these letters are answered within four weeks; seven more are answered after the station sends a follow-up query a month later; and the remaining ten letters are blandly ignored by the doctors even after numerous requests. When a pre-inductee reports a disorder which is not detectable at a single physical examination (asthma, for example; or epilepsy), the station asks the doctor for a case report. What is wanted is the same kind of report a conscientious physician sends to a medical colleague. These reports, remember, go to the medical officers at the induction station: they go, in other words, to our professional brethren.

What can the induction station do when the doctor's report is manifestly inadequate, or when the query is ignored? They either send the selectee, for observation, to an Army hospital—meaning a considerable loss of time and a considerable nuisance to the young man, plus the cost (to you and other taxpayers) of transportation and hospitalization; or he must be given several phy-

sical examinations after which, if no evidence of the alleged illness is found, he will be inducted. If later, he shows clinical manifestations, the Government must go to considerable expense to discharge him, and there is no calculating the cost to the young man in unnecessarily interrupted business or college life. All of this would have been avoided by a compact report from the family doctor.

Of the answers that *are* sent, about one half are of the one-line variety that no doctor can be proud of. "I treated John Smith for asthma five years ago" is a typical example. Of what value is this in determining the selectee's military fitness? It can be stated that if the answer includes laboratory findings, summarizes the history, recites the effectiveness (or ineffectiveness) of treatment, and otherwise measures up to sound standards, the result will be that the young man will be considered as having the condition which his private practitioner diagnosed, and will be classified accordingly. If the doctor fails to support his own patient's story, either by sending a hopelessly inadequate reply, or by refusing to submit any answer, then he is certainly failing his patient at a time when all concerned really need the information which the doctor has locked in his files. It is uncomfortable to find that half of the doctors queried by the induction station in this connection, have failed to furnish the documentary evidence which their own patient needs. *Verbum sat sapienti.*

STUDENTS' MEDICAL JOURNAL

January 1952 saw the first issue of the *Journal of the Student American Medical Association*. This periodical, which will be issued monthly (except during the summer) is a full-sized, slick paper, multi-color job. The first issue runs to 78 pages. Aimed primarily at medical students and interns, it contains a nice balance of scientific, administrative and educational articles. The scientific papers are written in mature style, in no way talking down to the students. They are lucid and make useful reading to the seasoned practitioner as well as to the senior student. The January issue has an article on the history and structure of the American College of Radiology, and another on the American Heart Association. There is a profusely illustrated article on the College of Medicine of the University of Illinois — presumably the first in a series. There is an historical item on Hippocrates. Three full-sized scientific articles are included—one on bronchiectasis, one on nephritis, and one (by a senior medical student) on a tubercule bacillus vaccine. Features include newsletters, editorials, abstracts, legislative notes from Washington, letters to the editor and book reviews. And there are organizational items about both the A.M.A. and the Student A.M.A. If the editors can maintain the high standard set in the first issue they will have done something that sounds incredible: added to the growing roster of medical journals a new periodical that is really needed and really useful.

ORIGINAL ARTICLES

THE CANCER PROGRAM IN NEW JERSEY, PART VI.

ADMINISTRATION OF A RADIO-ACTIVE ISOTOPE * PROGRAM IN NEW JERSEY

The Advisory Committee on Cancer Control of The Medical Society of New Jersey and the Executive Committee of the American Cancer Society, New Jersey Division, Inc., have approved the outline of a radio-active isotope program as part of the cancer control program in New Jersey.

The plan envisions the establishment of an Isotope Therapeutic Center at one or more general hospitals in the state and the setting up of branch centers at a number of other hospitals conveniently located in various parts of the state.

An Isotope Therapeutic Center (fully approved by the Atomic Energy Commission) has been established at Newark (N.J.) Beth Israel Hospital as described in an article in that hospital's Journal last year.* This center has been partly financed by funds of the American Cancer Society and will act as the center of the radio-isotope program which will be financed by the American Cancer Society under the supervision of the Advisory Committee on Cancer Control.

Other hospitals and clinics in New Jersey may wish to establish an isotope program in their own facilities. It is possible for an approved user of isotopes to serve also as a secondary distributor of the materials to other approved users. In this case, other hospitals should apply for isotopes in the same manner as Newark Beth Israel Hospital and file for acceptance as required by the Atomic Energy Commission. They should state in their application that the isotopes are to be procured from Newark Beth Israel Hospital. When their program is approved, authorization for radio-isotope procurement will be issued to allow them to obtain the isotopes from Newark Beth Israel Hospital instead of directly from the Oak Ridge National Laboratory.

Under present regulations of the Atomic Energy Commission radio-active iodine or I^{131} can be administered for therapeutic or other purposes to patients only at the isotope center at Newark Beth Israel Hospital. Radio-active phosphorus, P^{32}, can be transmitted from Newark Beth Israel Hospital to branch centers which may be established under the approval of The Medical Society of New Jersey and under the financial assistance of the American Cancer Society. In each of these cases where P^{32} is to be transmitted from Newark Beth Israel Hospital to a branch Isotope Center, approval for establishment of such a branch center must be given by the Atomic Energy Commission as well as by The Medical Society of New Jersey's cancer control committee and the American Cancer Society's state executive committee. Certain instruments needed for the administration of this program in branch centers can be provided from funds of the American Cancer Society.

The administration of radio-isotopes to patients who are certified by referring physicians as indigent or medically indigent can be financed by American Cancer Society funds. Patients with carcinoma of the thyroid needing the administration of I^{131} must be sent to the isotope therapy center established at the present time at Newark Beth Israel Hospital or such centers as may be established in the future by approval of the Atomic Energy Commission at other hospitals. Based on a cost accounting survey the American Cancer Society will authorize expenditure of $20 per patient per treatment for the administration of I^{131} at the isotope therapy center. The Cancer So-

* For technical information concerning the development of a radioactive isotope program in a general hospital see *Journal of the Newark Beth Israel Hospital*, Newark, N. J., for January 1951 available through the American Cancer Society, New Jersey Division, Inc., 9 Clinton Street, Newark 2, New Jersey.

ciety will not authorize expenditures for non-malignant cases.

Patients with malignant disease requiring the administration of P^{32} will not of necessity be referred from branch centers to the Isotope Therapy Center at Newark Beth Israel Hospital or to such centers as may be established in the future. Under regulations of the Atomic Energy Commission, the Isotope Therapy Center is not permitted to transfer I^{131} to other centers, but it may so transfer P^{32}. This will be provided by the Isotope Therapy Center to branch centers on application properly signed by the attending physician or the clinic director. The American Cancer Society will pay the expense of the P^{32} treatment at the rate of $20 per patient per treatment from patients certified by the attending physician or the hospital social service department as indigent or medically indigent.

It is emphasized that radio-active isotopes should be under the supervision of one certified in radiology or therapeutic radiology.

A special committee to formulate desirable standards of qualifications to permit radium in hospitals in its report to the American College of Radiology in November 1950 pointed out that "no one shall be permitted to use radium, its derivatives or radio-active isotopes unless screened and approved by the director of the department.

"Where this is not practicable a committee on radium and radio-active isotopes shall be established, composed of a therapeutic radiologist, a physicist, a gynecologist, urologist, surgeon and internist, each certified by his respective board.

"This committee shall determine who from experience and training shall be permitted to use these modalities and under what conditions. If after permission to use these substances is granted, a staff member applies the same in a manner not consonant with current knowledge then their use in the future should be denied."

It is emphasized by the Advisory Committee on Cancer Control and the American Cancer Society that approval and/or financial assistance will be given to no isotope therapy center or branch center that has not first been fully subjected to the regulations of the United States Atomic Energy Commission, Isotopes Division, and which has been approved by the commission as a center or branch center for the use of radio isotopes.

Members of Cancer Control Committee: Dr. William O. Wuester (Chairman), Drs. William E. Bray, James S. Gallo, Otto R. Holters, Joseph I. Echikson, W. James Marquis, H. Wesley Jack, John L. Olpp, Nicholas M. Alter, Frank M. Mastroianni, George P. Koeck, Victor B. Seidler, Salvatore Giordano, Joseph Camarda, and Royal A. Schaaf.

TALK ON EMPHYSEMA

Meeting of the N. J. Chapter of the American College of Chest Physicians will be held on Tuesday, May 20, 1952, at the Chalfonte Hotel in Atlantic City.

Dr. Martin Sokoloff, Associate Professor of Medicine, Jefferson Medical College will talk on "Recent Advances in Our Knowledge of Pulmonary Emphysema", at a luncheon meeting.

All physicians attending the Annual Meeting of The Medical Society of New Jersey or those in Atlantic City are welcome to participate.

RUBBER STAMP

A doctor in San Francisco plans to use a rubber stamp—a duplicate of the new A.M.A. office plaque—on his monthly statements as an incentive to his patients to talk over professional services and fees, thereby building a feeling of understanding between physician and patient.

RADIOLOGY RESIDENCY AVAILABLE

A fully approved radiology residency is now available in Newark. Salary will be $2400 for the two-year period, payable at $100 per month. Maintenance, including room, board, lodging, and laundry will also be provided. Interested physicians should apply to Dr. P. J. Gianquinto, Radiology Department, St. Barnabas Hospital, 685 High Street, Newark 3, N. J.

L.I.C.M. ALUMNI DAY

The annual Alumni Day of the Long Island College of Medicine and the State University of New York at New York City College of Medicine will take place on April 26, 1952. There will be a scientific session at Polhemus Clinical Hall followed by the annual business meeting. There will be interfraternity activity in the afternoon followed by the Annual Dinner at the Columbus Club, Prospect Park West, Brooklyn, at 7 p. m.

FUNCTIONAL DISEASE OF THE COLON*

ROENTGEN STUDY BASED ON 200 CASES

Robert J. Gross, M.D., Newark, N. J.,
Oscar H. Cohen, M.D., Boonton, N. J., and
C. R. Weinberg, M.D., New York, N. Y.

Review of the x-ray literature for the past twenty years discloses many articles on the diagnosis and differentiation of organic diseases of the large intestine. In marked contrast is the paucity of reports concerned with the roentgen diagnosis of *functional* disturbance of the colon for which no organic substrate can be found.

Criteria for the diagnosis of functional disturbances of the colon are important. As Bockus[1] has recently said, "symptoms due to colonic dysfunction account for a greater number of visits to the gastro-enterologic internist than does any other clinical syndrome". It is, therefore, surprising to find that the radiologic literature, at least, does not contain ready reference to a set of criteria of value to the roentgenologist as an aid in establishing the presence of functional disease; that is, if such criteria really exist.

The functional colon syndrome has been given many different names, such as irritable colon, spastic colon, spastic colitis, mucous colitis, and others. Actually, these terms refer to a symptom complex consisting of diffuse or localized abdominal pain or discomfort, abdominal distention, headaches, weakness, nausea and bad breath, almost invariably accompanied by constipation, diarrhea, excessive mucus, or various combinations of these symptoms.

Study of routine hospital and private office reports of the roentgenographic examination of the colon reveals a chaotic situation. Many radiologists and clinicians use no consistent criteria of functional disease, and make the roentgenographic diagnosis frequently and haphazardly. At the other extreme, are those radiologists who say that where there is no evidence of organic pathology, no colonic dysfunction or disturbance exists. A third group is made up of those who, depending on the literature they have been exposed to or discussions they have heard, or perhaps for a more remote reason, sometimes will, and sometimes will not, call a particular colonic pattern abnormal and indicative of a functional colonic disturbance.

Yet, some criteria *have* been evolved for the diagnosis of functional disease of the colon. Many doctors want to diagnose functional disease simply by ruling out an organic lesion. Sante[2] believes that mucous colitis is demonstrated by spasticity and hypermotility of the colon with occasional demonstration of long narrow strands of barium (representing mucus coated with the barium) the so-called "string sign". He groups constipation into two categories: the hypertonic and the hypotonic. Golden[3] uses this rough estimate in evaluating spastic colon: when the sigmoid and descending colon are less than one-third the diameter of the ascending colon, the former are considered hypertonic or spastic. This is frequently associated with "irritability" manifested by rapid passage of barium or hyperperistalsis. He believes roentgen evidence of spastic colon more reliable by enema than by meal. However, he emphasizes that, normally, the propulsive mechanism in the colon is not immediately followed by relaxation and the lumen may appear narrowed without necessarily indicating abnormality. Kruse[4] describes the following changes in functional colonic disturbance: spasm, particularly in the descending and sigmoid portions; peristalsis and anti-peristalsis; excess mucous secretion manifested by a "string sign". In his experience, the normal bowel empties only partly

* From the Department of Radiology, New York Medical College; Flower and Fifth Avenue Hospital.

1. Bockus, Henry L.: *Gastro-Enterology*. Saunders, Philadelphia. Volume II, page 475 (1944).
2. Sante, L. R.: *Principles of Roentgen Interpretation*. Edwards Bros., Ann Arbor, Mich., page 282 (1949).
3. Golden, Ross: *Diagnostic Roentgenology*. Nelson, Baltimore, Volume I, page 343 (1947).
4. Kruse, Fred H.: Journal of The American Medical Association, 103:1366 (November 3, 1944).

whereas the irritable bowel empties almost completely, as noted on post-evacuation film. Evaluation of a motor meal must take into account the normal function of the colon. Wallace *et al.*[5] found that a normal colon may take as long as 120 hours to empty and only a small group of cases (8 per cent) evacuate completely in 24 hours. Stierlin[6] divided colonic stasis into two groups: one showed a diffuse stasis over the entire bowel, and in the other stasis was limited to localized areas of the colon. Bargen[7] did not consider the formation of the "string" as pathognomonic of colonic disturbance. He found that the so-called "string sign" may appear independent of any intrinsic disease of the colon. Buckstein[8] states that functional diarrhea due to a disturbance of the colon is shown by hypertonicity and hypermotility. A barium meal appears with abnormal rapidity in the sigmoid and within 24 hours or less the colon may be almost entirely empty.

A review of these statements conveys little that is tangible, and nothing that would enable one to evaluate colonic dysfunction. No criteria are given to serve as standards for a definite diagnosis of functional disease. Changes such as spasm, stasis, hypermotility, caliber of the lumen, irritability, et cetera, are mentioned in such a general manner as to exclude their use for firm diagnostic criteria.

It is important for the radiologist to know the criteria that the gastro-enterologist uses in making a diagnosis of irritable colon. Bockus[1] states that the diagnosis is based upon the history together with exclusion of other causes for the symptomatology. Physical examination may reveal tenderness or stiffness of the distal portion of the colon; abnormally shaped stools; and discharge of mucus. Proctosigmoidoscopy may disclose a hyper-irritable, spastic sigmoid or excessive mucus. Bockus[1] says that the most important objective finding is evidence of muscular irritability of the colon, as disclosed by a progress meal study and a barium enema. Among the roentgen changes listed by Bockus[1] in the irritable colon are: rapid passage of barium, production of pain similar to the discomfort for which the physician's aid has been sought, narrowing of some segment or segments of the colon, and sometimes fine, shallow, irregularly arranged saw-toothed margins of the colon wall, particularly in the pelvic portion of the colon. One of the most striking roentgenographic appearances in irritable colon is that of complete absence of haustral markings associated with extreme narrowing of the colon, producing an appearance suggestive of ulcerative colitis. If this finding is inconstant, it is suggestive of functional origin.

To attempt a formulation of criteria for functional colonic disease, a series of 200 consecutive cases was analyzed. These were patients in whom barium enemas were done and in whom no organic disease was found. Routine preparation of all patients included two ounces of castor oil the evening prior to examination and a cleansing enema the morning of examination. The opaque mixture was a simple suspension of one part barium to two parts water at body temperature. Each case was evaluated with respect to the ordinary criteria utilized by radiologists. These included: spasm, redundancy, emptying of the colon, haustration, "string sign", position of the colon, and diameter of the colon in the sigmoid region when full and after evacuation. Buckstein[8] points out that care must be taken in the interpretation of spasticity because the lumen of the descending colon is normally smaller and has a thicker musculature than that of the proximal portion. He states that some degree of contraction or spasm of the descending colon is ordinarily present. The distribution of a small amount of opaque material may give the impression that the lumen of the colon has been narrowed; yet that narrowing may be due to normal tonic activity. A film taken after a bowel movement may also show a markedly diminished lumen due to the decreased content and may simulate the appearance of a markedly contracted abnormally spastic colon. This is particularly true after a mass movement. Spasm was graded as plus 1 or plus

5. Wallace, R. P. *et al.:* American Journal of Roentgenology, 39:64 (January 1938).
6. Stierlin, E.: Muenchner Medizinische Wochenschrift, 58:1906 (December 1911).
7. Bargen, J. S.: American Journal of Roentgenology, 25:308 (1931).
8. Buckstein, J.: *The Digestive Tract in Roentgenology.* Lippincott, Philadelphia, page 565 and page 577 (1948).
9. Burst, J. C., and Childs, D. S.: *Clinical Radiology.* Lippincott, Philadelphia, Volume I, page 598 (1946).

2 when the caliber of the lumen was reduced by one-third; plus 3 when the caliber was reduced by one-half; and plus 4 when the caliber was reduced by more than one-half. No measurements could be devised to evaluate degree of haustration. Measurements of the colon were made in the sigmoid portion at the margin of the pelvic brim. These measurements of the diameter of the bowel lumen were subsequently disregarded because they were non-contributory. Redundancy was graded objectively as to the extent of the tortuosity. See the figure on this page. For this evaluation, redundancy of grades 1 and 2, as well as spasm, grades 1 and 2 were considered within normal limits. Correlation of the position of the bowel (high or low transverse), location of flexures, et cetera, were also analyzed and disregarded as non-contributory. The patients in this group ranged in age from 15 to 81 years, with an average age of 43. The series included 133 males and 67 females.

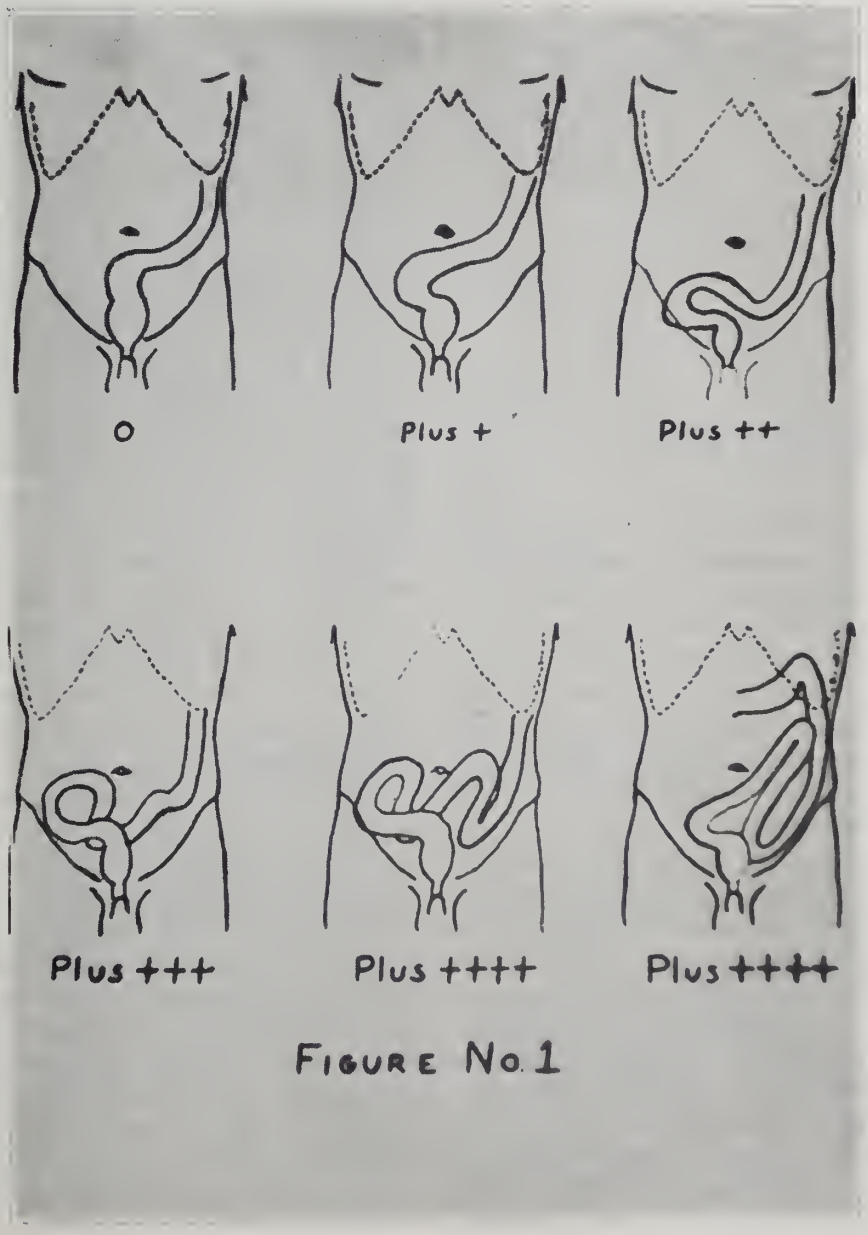


FIGURE No. 1

TABLE I
SUMMARY OF 200 CASES

	Cases	Ratio
Patients with complaints*	177	88%
Patients with no complaints	23	12%
Patients with pain	145	73%
Cases of diarrhea or mucus in stools	53	26%
Patients with mucus, diarrhea and constipation	12	6%
Patients with roentgen signs of spasm	8	4%
Patients with roentgen signs of "poor" to "fair" emptying	112	56%
Patients with roentgen signs of "good" emptying	88	44%
Patients with roentgen signs of redundancy	65	33%

* Complaints—generalized or local abdominal pain or distress, bloating, diarrhea, mucus, constipation, nausea, "gas".

TABLE II
REDUNDANCY CASES — 65

	Cases	Ratio
Patients with no symptoms	4	6%
Patients with symptoms	61	94%
Constipation	30 or 45%	
Mucus or diarrhea	12 or 18%	
Pain	19 or 31%	
Patients with "good" emptying	22	34%
Patients with "poor" to "fair" emptying	43	66%

TABLE III
PATIENTS WITH PAIN — 145

	Cases	Ratio
Patients with constipation	40	27%
Patients with spasm, mucus and diarrhea	2	1%
Patients with mucus and diarrhea	44	31%
Patients with redundancy	45	31%

Criteria of roentgenologic diagnosis are constantly being re-evaluated and modified. What is sought in a roentgenogram are changes which may be grouped in various diagnostic patterns. Depending upon the pattern, we speak of these groupings as the criteria of diagnosis. Medically speaking, however, any consistent finding that a trained observer may report about a specific situation can be considered as one criterion for diagnosis.

A basic term which may be used by convention to describe any elementary change or characteristic is the word "attribute". This is a term used by a trained observer to describe any change pertinent to the subject he is studying. An abnormality can then be considered as a recognized grouping of attributes into a pattern. The radiologist utilizes attributes derivable from radiographic procedures as the basis for his opinion or diagnosis. However, as a physician, he cannot rely entirely upon those attributes which he observed on fluoroscopy or in his films. Other attributes are contained in data pertaining to the history, physical findings and laboratory reports. These, too, are necessary for complete evaluation. This is particularly true when a diagnosis of functional disease is attempted. It is common to associate fortuitous attributes in extending a diagnosis of some abnormality. In functional disease of the colon, many of the attributes which were believed to be diagnostic may actually be fortuitous findings.

Of all the attributes evaluated, only redundancy of the colon and degree of emptying showed statistically valid correlation with functional bowel complaints. Even here, however, the correlation was imperfect. Not every patient who has redundancy of the colon, or poor emptying, could invariably be given a roentgen diagnosis of a functional colonic disease. The senior author was able to observe serial films of the colon on patients who had been hospitalized at a psychiatric institution for periods up to thirty years. A number of these patients, because of chronic mental disease, were unable to feed themselves properly, secure proper diet, or exercise properly, and commonly suffered from constipation. Films of these patients over a period of years showed a definite change in the appearance of the large bowel. The colon became elongated, widened and redundant. After a period of years, the constipation became refractory to any type of therapy. This gives additional support to the correlation of constipation with redundancy.

Many complaints depend, to a large extent, on the emotional attitude of the patient toward his bowel habits. For example, there are patients who feel that having two or three bowel movements a day is not unusual and consider those bowel movements normal. There are others who move their bowels as infrequently as once or twice a week and still consider their movements as normal too. Disturbances of the colon are a common response mechanism to the stress and habits of our contemporary civilization. Poor bowel habits, insufficient exercise, frustrations and conflicts, variations in the diet and many other factors may cause a change in the bowel habit associated with symptoms. There is no constancy in the symp-

tomatology of these patients. Their complaints vary intermittently and sometimes can be closely correlated with environmental stimuli which cause stress or mental conflict.

The roentgenologist should not make a conclusive diagnosis of a functional disturbance of the bowel, particularly if irritative preparations (such as castor oil and irritating enemas) have been used as a part of the examination. The roentgenologist's function should primarily be to eliminate the possibility of organic disease, ensure proper evaluation of the colon by describing the symptoms elicited by the enema, the variations in the tonus of the bowel, the degree of redundancy, the length and caliber of its various loops, the changes in the mucosal pattern, the amount of tenderness over its various segments and the degree of emptying on evacuation. Although it was not subjected to statistical evaluation, it was found that questioning the patient about the pain elicited by the enema, routinely was helpful in evaluating the findings. Frequently, patients with functional disease reported distress similar to their original complaints. Findings which fit in with the syndrome of functional disturbance of the colon may be reported "as consistent with the diagnosis of colonic dysfunction". However, the roentgenologist should always keep in mind that there are many patients with redundancy of the loops of the colon and what appears to be spasm of the bowel, who do not have any complaints and who, therefore, do not have a functional disturbance.

SUMMARY AND CONCLUSIONS

1. A review of the literature fails to reveal useful roentgen criteria for the diagnosis of functional disease of the colon.

2. Two hundred consecutive cases of functional disturbances of the colon were analyzed and symptomatology and signs correlated with roentgen changes.

3. The only changes found to be statistically correlated with functional disease of the colon were redundancy and degree of emptying. A helpful symptom was the type of pain elicited by the enema. The roentgen diagnosis of spasm could not be substantiated.

4. Findings should always be interpreted in correlation with other clinical attributes, and should not be used by themselves as the sole criteria for diagnosis of functional disease.

31 Lincoln Park, Newark

115 Church Street, Boonton

2 East 105 Street, New York

SUBARACHNOID HEMORRHAGE DURING PREGNANCY

Spontaneous subarachnoid hemorrhage is a serious cerebrovascular disturbance at any age of life, and is due to leakage from a faulty vessel wall, rupture of an aneurysm or of some other vascular anomaly. Its occurrence during pregnancy is especially hazardous to the mother, and it is imperative to determine whether there is an associated toxemia of pregnancy. In the October 1951 *Archives of Neurology and Psychiatry*, J. W. Conley and C. W. Rand review 20 cases of subarachnoid hemorrhage occurring during pregnancy in noneclamptic women, and have added eight cases of their own. They urge that when subarachnoid hemorrhage occurs, if the patient's condition permits, cerebral angiography be done. Only by this means plus appropriate neurosurgery may the cause be eliminated, if it is an accessible aneurysm or vascular anomaly. If the source of hemorrhage cannot be demonstrated, absolute and strict bed rest should be enforced for several weeks.

These authors feel that cesarian section is the method of choice of delivery as it obviates the "strain" of natural delivery. In addition, future pregnancies should be avoided by sterilization, as they place the patient in added jeopardy.

THE TEEN-AGE NARCOTIC PROBLEM IN NEW JERSEY*

Evelyn P. Ivey, M.D., Morristown, N. J., and
J. Lawrence Evans, Jr., M.D., Englewood, N. J.

In New York City and in certain other parts of the country, there has been an increase in the number of children addicted to heroin. In New Jersey, however, the problem has been relatively slight though, of course, just as tragic to the individuals and families concerned. In general, this abuse of the drugs tends to concentrate in metropolitan districts and is relatively infrequent in rural areas. Some arrests have been made in New Jersey but there are few teen-age addicts in this state. We are grateful to our public officials for effectively limiting the indiscriminate availability of marihuana and heroin. Recent widespread public interest in this is good in that it alerts the public and stimulates interest in prevention.

Drug addiction at any age is a symptom of an emotional disturbance that requires treatment. Treatment is best conducted in a hospital where a multiple-disciplined[1] approach may be effectively employed to treat the physical, emotional and sociologic aspects of the problem. Since the problem is minimal in New Jersey, existing hospitals should be able to absorb those needing treatment. *Treatment* should be stressed: punitive measures are best reserved for chronic offenders, uncooperative addicts or for those with criminal involvement. Court action may be used constructively in terms of probationary supervision and as a stimulus to helping the addict face the reality of his need for treatment, or of insuring continuation of treatment until it has been completed.

We should like to see addiction declared an illness, reportable to the State Department of Health. This would be a sound way of obtaining valuable information as to the extent, nature and distribution of addiction.

PREVENTION

The first important item of prevention is that of seeing that the drug is not available. We have confidence in the ability of our legislators and law enforcing agencies to control this factor.

Another aspect of prevention deals with the reaction of the individual which makes him resort to the use of drugs for relief. The stable teen-ager or adult may use drugs because of curiosity or on prescription from a physician and then give them up spontaneously. Drug addiction is a symptom of personality disturbance. Prevention necessitates the full utilization of, and improvement in, all community resources which may influence mental health. Thought should be given to the adequacy and ways of improving such general activities as schools, housing facilities, recreational programs, public health, and child welfare agencies.

Education is necessary for prevention. Facts about the teen-age narcotic problem provide the public with the knowledge of how they can fight it. The teen-ager should know that it is not smart or daring to take drugs, but rather that it is the sign of a need for artificial help to meet life. He should be taught the effect of drugs as he is taught the effect of alcohol and should know that the use of drugs may lead to addiction. Care should be taken that only reliable and unbiased information reaches our teen-agers. We recommend that the film library of the Department of Institutions and Agencies make available a film which presents the facts and which can be shown to young people in junior and senior high schools. In this way the subject could be treated factually but casually as one of the many public health problems of today.

Education along mental hygiene principles is included in many schools at the present

* This represents the report of two committees of the New Jersey Neuropsychiatric Association. Dr. Ivey is chairman of the Committee on Community Mental Health. Dr. Evans is chairman of the Committee on Public Relations.

1. As used here the word "discipline" does not mean what it might appear to mean to a lay reader thinking of the problem of addiction. "Discipline" here means a doctrine or mode of practice; psychiatry, social work, public health, psychology, jurisprudence, sociology and the like are the various "disciplines" which, together, make up the "multiple disciplined" approach referred to by the authors—*Editor.*

time. This might be more successfully implemented if teachers were helped through work shop courses to have better understanding of themselves in relation to other people.

Prevention of emotional illnesses has its greatest hope in healthy family relationships. Parental understanding and stability are essential. More educational opportunities for parents are needed. Obstetricians and pediatricians can be helpful in guiding parents to seek psychiatric treatment early.

The use of mental hygiene facilities by schools should be increased. Difficulty in school may be indicative of personality trouble and affords an excellent opportunity for early diagnosis and treatment. Mental hygiene facilities should be available for every man, woman and child.

REHABILITATION

Rehabilitation of the drug addict is the weakest link in the treatment at present. It is important that this be strengthened since individuals who have been addicted frequently become peddlers or leaders in influencing young people to take the drug. Again, education of the public is essential because the current moralistic attitude impedes the rehabilitation of the addict in society. Supervision of the treated addict must be carried on by trained individuals who can give supportive help on the basis of their understanding. This may be done by probation officers if they have psychiatric social work training or by agencies that include this as one of their functions. Narcotics Anonymous can be very helpful in the rehabilitation of the drug addict. Whatever agencies are used, there should be systematic referral for supervision of the treated addict.

The threat of drug addiction in our teenagers should serve as a further stimulus to increase our efforts toward promoting mental health in all individuals.

Members of the Committee on Community Mental Health, in addition to Dr. Ivey were Dr. Theodore Gebirtig, Dr. Laura Morrow, Dr. Julius Sobin, Dr. Bernard Goldberg and Dr. Francesco Figurelli. The Committee is also indebted to Dr. William Gonss, Dr. George Davies, and the Committee on Correctional Psychiatry for sharing the results of their experience in this field.

3 Community Place
240 East Palisade Avenue

ARMY REQUESTS COOPERATION ON MEDICAL INFORMATION

The following letter, received from the Chief Medical Examiner of the Army and Air Force Induction Station is published for the information of all concerned:

Dear Sir:

For the past six months, I have had the privilege of working with a small segment of the physicians of New Jersey in the capacity of Chief Medical Examiner of the Combined Armed Forces Examining and Induction Station for New Jersey.

To the physicians, who have responded completely and promptly to our request for medical information relative to the inductees that we examine, I would like to express my sincere thanks and appreciation.

There is unfortunately an occasional physician who does not realize the importance of prompt, accurate and honest answers to the letters which we may send them asking for medical histories. I realize the over-abundance of paper work that most physicians are now burdened with. It, however, is extremely important to the whole future of every young man in New Jersey that we be acquainted with an accurate appraisal by their family physicians of their past medical history. Too many physicians are under the impression that their letters are of no importance. This is far from the truth. We would appreciate it if every New Jersey physician, when informed by their patients that they are to report for a pre-induction physical examination, would give to the pre-inductee a complete summary of the important medical history for presentation at the time of examination.

Again, may I express my thanks to the New Jersey medical profession for their past cooperation and their future continued aid.

Sincerely yours,

STANLEY STARK, Captain, MC
Chief Medical Examiner

TRICHLORETHYLENE IN OBSTETRICAL ANESTHESIA

M. FENSTER, M.D., and HERMAN LEVY, M.D., Passaic, N. J.

In the quest for an ideal anesthetic, the search has been for a safe, non-explosive anesthetic which is easy to administer. Trichlorethylene in obstetrical anesthesia and analgesia has been used in our hospital[1] (which could be considered an average small-town hospital) with a great deal of success. Trichlorethylene can be recommended for use in a hospital that has no highly trained anesthesiologist, because of its simplicity in administration.

Trichlorethylene (also spelled trichloroethylene) is marketed by various companies, usually under trade names. We used the brand known as Trilene,[2] and several other good preparations[3] are also available. It is a heavy fluid, and since its boiling point is 87° C, it cannot be vaporized on a mask. Though used fairly widely in Britain and Canada, it is not a popular general anesthetic in the United States, possibly because of early reports[4] which suggested that it could produce cardiac or respiratory complications. And it is certainly true that trichlorethylene should not be used when deep surgical anesthesia is required. We use it, as indicated below, for light obstetrical anesthesia only.

1. Beth Israel Hospital, Passaic, N. J.

2. Made by Imperial Chemicals, Manchester, England, and distributed through the Canadian office of that company in Toronto.

3. Some companies prepare it only in small capsules to be broken and inhaled for trigeminal neuralgia. In this form, it is not suitable for general anesthesia. Davies, Rose and Company of Boston market it under the name of Trethylene, in one ounce bottles, usable for general anesthesia.

4. Waters, A. R., Orth, O., and Gillespie, N.: *Anesthesiology*, 4:1 (January 1943).

5. Hewer, C. L.: Canadian Medical Association Journal, 62:324 (June 1950).

6. We use the type known commercially as the "Cyprane" Inhaler. It is made by the Eppis Manufacturing Corporation of Kenosha, Wisconsin.

ADMINISTRATION

Trichlorethylene will produce analgesia in the first stage of labor, through the use of a special "self-administration" inhaler.[6] A few drops of trichlorethylene are deposited in the inhaler. The patient inhales the anesthetic during the labor pains by pushing a button. If the anesthesia is too deep, the button is released, stopping the flow of the vapor, thus discontinuing the anesthesia automatically. For anesthesia given by the anesthetist, the trichlorethylene is placed in the ether or vinyl ether jar of the ordinary Foregger or McKesson machine. For induction, four liters of nitrous oxide and four liters of oxygen are mixed in the bag. The patient is told to inhale with every pain. For deeper anesthesia, for forceps delivery, or for suturing the perineum, the nitrous oxide and oxygen mixture is bubbled through small amounts of trichlorethylene, just enough to produce first plane, third stage anesthesia. Soda lime cannot be used with trichlorethylene, because the anesthetic reacts with alkali to produce toxic substances.[5] Since in routine obstetrics, deep anesthesia is rarely requested this has been found to be satisfactory for both the mother and the infant. The cardiac and respiratory abnormalities encountered were of no significance in our 200 cases. The number of women who vomit following the anesthetic is surprisingly low. This is important in view of the reports of fatalities occurring, because of aspiration of small pieces of food, during vomiting. Very few infants had to be resuscitated. In many cases, sedatives are used during the first stage of anesthesia, causing difficulties in the newborn.

202 Lexington Avenue

CLINICAL DIAGNOSIS AND CASE MANAGEMENT*

Gordon Vail Stoddard, M.D., East Orange, N. J.

A nation-wide study is under way to determine methods of cutting the costs of medical care. Features of this survey include efforts to shorten the patient's stay in the hospital, reduce costly diagnostic procedures (where their use has become more routine than necessary) and curtail wasteful, and again, routine use of exceedingly high priced drugs.

The purpose of this paper is to emphasize the fact that by stressing *clinical* diagnosis in our thinking we may often obviate the more complicated diagnostic methods; and by clarifying the clinical picture we may avoid overprescribing.

A construction engineer once told me that bridges are built to specification equal to a peak load, plus the factor of safety. "In reality", he said, "this is the factor of ignorance". Applied to medicine we might, to give a crude example, prescribe for an erysipelas enough antibiotics to control a subacute bacterial endocarditis. In this connection reports have come in recently, of fantastic hospital bills in uncomplicated illnesses. Analyses revealed countless laboratory procedures and fabulous amounts of special medications. Apparently the physicians were allowing for every eventuality and not placing sufficient faith in their own clinical judgment.

Overuse of the powerful new "wonder-drugs" is not without hazard to the patient. Such bogging down of the system with medicines might be likened to the dilemma of the paratrooper who put on four parachutes just to be sure that one would open; but the four became so tangled that none of them worked. Tangled medications are all too frequently encountered.

There is a saying, quoted by Fairless[1] that a good executive is a man who goes around with a worried look—on his assistant's face. On the contrary, I believe that a good clinician does some worrying himself, and does not leave it all to the laboratory and x-ray department. To the present-day medical student and to those doctors commencing practice, a careful history, meticulous study of physical signs, and the use of simple tests, must seem very unglamorous when compared to the bright array of new devices for penetrating the mysteries of cellular metabolism and endocrine chemistry; but until we have a body-tuning device that will hand us the diagnosis on a slip of paper, we will have to use a combination of old and new methods. Frequently the old method is the true short-cut; for example, percussion rather than x-ray to demonstrate a pleural effusion. We have the airplane, but we must not forget how to walk.

For a moment I would like to return to two fundamental principles: *first,* despite all the marvels of this golden age of medicine, it is the *body,* not the doctor, that has the healing power. We can supply what is lacking, we may inhibit, kill or neutralize invaders, and make structural repairs, but the body must respond, and resume a state of functional equilibrium, or our efforts are vain. I venture to say that the homeopathic school of medicine with its infinitesimal doses could not have survived so long, nor boasted so many followers, were it not that most illnesses are overcome by the body itself in the presence of little or no medication. The natural state of the body is health, not ill-health. The influenza pandemic of 1918 taught a lesson. Lacking an effective drug, all sorts of coal tar derivatives and heart stimulants were tried; but the lowest mortality rates were achieved where treatment was limited to nursing care.

The *second* fundamental principle is: when a vital tissue is destroyed the body dies. We try to save the patient as long as a chance to do so remains; and where doubt as to diagnosis exists, no complicated technic should be spared, nor should costly drugs be omitted; but there are times, even in treating the critically ill where stopping a medicine will be wiser than adding one. The fact that the pa-

* Read by invitation before the staff of the East Orange (N.J.) General Hospital on January 14, 1952.

1. Benjamin F. Fairless, President of the United States Steel Corporation.

tient's condition worsens under a certain medication should lead us to ask whether the medicine itself is not an additional burden. Even food, when the body is not receptive, can be as noxious as drugs. Statements of this sort need verification by examples. The few given here are presented in the hope that the reader will mentally add a score of his own.

Concerning food: it is not unusual to see the newly hospitalized coronary occlusion patient placed on a soft diet. Almost invariably the patient regurgitates that food. This clinical observation suggests the order: nothing by mouth except sips of water for twenty-four hours or more. Food eaten when fatigued or emotionally upset is poorly tolerated; but test animals on minimum diets are many times more resistant to infection than those on unrestricted food allowance. The most startling proof that food can punish the body is found in the pages of history. During the siege of Paris in the Franco-Prussian War and again in World War II where starvation diets were enforced upon a population, diabetes almost disappeared.

Concerning withdrawal of medications: a patient with gallstones, bundle branch block, loss of appetite and nausea, was admitted to the hospital for cholecystectomy. She was on full maintenance doses of digitoxin[2] and was taking a xanthine diuretic. Considering that she was seventy years of age and that her heart rate was slow, I thought she was taking too much digitalis and that the oral xanthine might be causing the gastro-intestinal irritation. As a test, both drugs were stopped. The gastro-intestinal symptoms of long standing disappeared, as did the bundle branch block. A load had been lifted. Surgery was uneventful, and the ventricular rate remained constantly normal.

Another patient, with a posterior wall myocardial infarction, had a fever for three weeks. The electrocardiogram showed a normal healing pattern. The spiking temperature curve led to a diagnosis of subacute bacterial endocarditis, a culture was taken and penicillin and streptomycin were begun. The fever persisted. A review of the patient's hospital course showed poor reaction to Dicumarol.[3] The white count had dropped from about 7000 to 3000 and neutrophiles had fallen to about 48 per cent. My thought was that since no valvular heart condition had been diagnosed, since the single blood culture was negative, the spleen not palpable, and petechiae absent, we had the right to question the diagnosis of subacute bacterial endocarditis and treat what did exist: a leukopenia of toxic origin. Accordingly antibiotics were stopped and a transfusion was given. On stopping the antibiotics, the previously present wheezes practically disappeared from the lungs and a skin rash cleared, but the temperature continued spiking. The day following transfusion the temperature rose as high as ever, and another antibiotic was proposed. Following clinical discussion, we agreed that this latest rise was a transfusion reaction, and advised waiting a day. The next day the temperature dropped for good, and recovery was prompt. Waiting is one of the most difficult and often one of the most rewarding clinical procedures. It is as reasonable to wait for the body to react, as it is to wait for oil to penetrate a hinge before the disappearance of the squeak.

Clinical diagnosis might be expected to take second place in cases being studied for modern cardiac surgery. We are prone to turn almost at once to cardiac catheterization and angiocardiography. But at Johns Hopkins Hospital the clear case of Tetralogy of Fallot is spared catheterization; and furthermore, history and inspection are as important as fluoroscopy and the electrocardiographic tracing. The machinery murmur is the pathognomonic sign in patent ductus arteriosus and to diagnose coarctation of the aorta the criterion is diminished or absent pulses in the lower extremity.

Finally, if we remember optimism in our clinical approach, scenes such as the following could be avoided. A young man had a severe grippe with high fever. Minor electrocardiographic changes (not uncommon after a virus infection) were discovered. Despite the lack of evidence of coronary involvement I heard the doctor ask the patient, "Do you want me to be frank?" The patient bravely replied,

2. One of the principal glycosides of *Digitalis Purpurea*.
3. This is the registered trade-name of the Wisconsin Alumni Research Foundation, who control the use of the word "Dicumarol".

"Go ahead, don't pull any punches". "Very well, in my opinion you have had a coronary attack". The doctor believed he was doing the right thing; but he was actually searching for a disease, not treating a patient. Even had he been correct in his diagnosis I think he was jumping the gun. The alarmist belongs in the same category as the witchdoctor; they both scare the devil out of their patients.

In closing, I urge that we spend our millions in behalf of health, but spend them efficiently. Remember Pyrrhus, King of Epirus, who in 279 B.C. defeated the Romans, but in so doing lost half his army. He said, "One more such victory and we are undone". I think that in medical practice we should win victories, especially over the common diseases, with simpler clinical strategy and at less cost.

96 Glenwood Avenue

ACUTE METHEMOGLOBINEMIA DUE TO ANILINE

REPORT OF A CASE

ADOLPH D. CASCIANO, M.D., Jersey City, N. J.

Numerous reports in the literature cite cases of methemoglobinemia arising from contact with substances containing aniline or its derivatives, such as the ingestion of crayons by children,[1,2,3] the use of diapers freshly marked with aniline ink,[4,5] and from other miscellaneous sources. There are very few references to its production by the pure chemical, however. Only one[6] could be found in the English literature. This was the report of a boy of 14 whose trousers, handkerchief and fingers became contaminated with aniline liquid in a chemistry laboratory when he sat on a chair on which the liquid had been spilled. An additional case is here reported.

On May 3, at 7:30 p. m., I received an urgent call to the home of a 20 year old chemical technician who stated that at 4 p. m. that afternoon he was distilling liquid aniline. The flask broke and about 35 cubic centimeters of the yellow liquid spilled on his abdomen. He got some of it on his hands also. He took a shower shortly after the accident but did not change his clothing until he reached home at 5 p. m. He showered again at that time. Gradually he began to feel weak; his arms and legs were "like lead". He developed a dull headache and noticed that his skin was becoming "dark". Past history was irrelevant.

The patient looked like a corpse. The skin was ashen grey. The mucous membranes, the tips of the fingers and toes and the lobes of the ears were purplish blue. In spite of his alarming appearance and great weakness there was no evidence of air hunger at rest. Blood pressure was 145/75 and pulse was rapid and regular at 120. Temperature was 98.4. The heart was not clinically enlarged. The heart sounds were of good quality; A2 was equal to P2. There was a soft blowing systolic murmur at the pulmonic area. The rest of the physical examination was within normal limits.

The patient was immediately hospitalized. Venous blood was drawn and showed a striking chocolate brown color. This was oxalated and kept tightly stoppered in the refrigerator over night in anticipation of a spectroscopic examination in the morning. Oxygen therapy was started by mask immediately after the blood was drawn. Since methylene blue was not available the patient was transfused with 500 cubic centimeters of whole blood over a period of two hours. Supportive therapy was instituted. So deep was the cyanosis at the time of admission that the floor nurse inquired if the patient was a Negro. Actually he was a Caucasian with fair skin and blond hair.

Within a period of three hours, the cyanosis had markedly diminished and the patient felt much better. The oxygen therapy was continued at intervals throughout the night. Next morning there was no trace of cyanosis. Except for slight dull headache, he felt well. The blood which had been taken on admission had lost its chocolate hue and looked like freshly collected venous blood. Unfortunately no facilities were available for spectroscopic examination. Grossly the methemoglobin had reverted to oxyhemoglobin.

1. Brieger, H.: American Journal of Public Health, 39:1023 (August 1949).
2. Jones, J. A., and Brieger, H.: Journal of Pediatrics, 30:422 (April 1947).
3. Clark, E. B.: Journal of the American Medical Association, 135:917 (December 6, 1947).
4. Graubarth, J. *et al.*: Journal of the American Medical Association, 128:1155 (August 18, 1945).
5. Howarth, Betty E.: Lancet, 1:934 (April 28, 1951).
6. Stening, S. E.: Medical Journal of Australia, 1:569 (April 21, 1951).

Blood count on admission was as follows: red cells, 5.39 million; hemoglobin 15.5 Grams; leucocytes 15,730; stab cells 1 per cent; segmented cells 80 per cent; lymphocytes 19 per cent. The following day he showed a count of 6.5 million erythrocytes and 18 Grams of hemoglobin. Urine examination on admission showed an alkaline reaction, specific gravity of 1.017, 2-plus albumin, negative for glucose and an occasional pus cell in the sediment. Fasting blood sugar was 99 milligrams per cent; NPN, 36. Kolmer and Mazzini tests were negative. Roentgen examination of the chest showed the heart and lungs to be within normal limits. An electrocardiogram taken on May 7 showed a diphasic T wave in lead 2 and an inverted T wave in lead 3. Precordial leads were within normal limits. There was a diphasic T wave in the AVF lead also. Another electrocardiogram done on May 10 showed the same findings.

The patient was discharged from the hospital on May 12 in excellent physical condition. Another electrocardiogram on May 19 now showed an upright T wave in lead 2 and a diphasic T wave in lead 3. The diphasic T wave previously noted in AVF was now upright. A slight hypertension of 150/68 persisted which was probably coincidental. The patient was discharged at this time apparently none the worse for his mishap.

Aniline is extremely toxic and reaches the body through the respiratory tract, the skin and mucous membranes. Most often the intoxication occurs by direct contact with aniline or its derivatives. It would appear that in the case presented most of the absorption was through the skin of the abdomen which remained in contact with the contaminated clothing for about an hour. His colleague who helped him wipe up the liquid suffered no ill effects.

The picture of acute methemoglobinemia is so striking that the diagnosis can be made clinically in many instances, if not always. Therapy must be started promptly. Spectroscopic examination is not necessary before treatment is begun. If this examination cannot be done immediately, the oxalated blood should be stored under oil in the refrigerator. No oil was used in this case and though tightly stoppered and refrigerated, the methemoglobin had grossly reverted to oxyhemoglobin within 15 hours. The severe anoxemia produced transient T wave changes. Although methylene blue intravenously is generally regarded as the treatment of choice it may not always be available. Transfusion and oxygen therapy were successful in this case.

189 Harrison Avenue

ARE COMPETITIVE ATHLETICS BAD FOR CHILDREN?

Highly organized competitive athletic leagues are undesirable for children and youth of elementary and junior high schools, according to Donald A. Dukelow, M.D., and Fred V. Hein, Ph.D., consultants to the American Medical Association Bureau of Health Education.*

"The public would do well to allow these youngsters to grow up without the unnecessary emotional and physical strain of playing gladiator in the public arena," Drs. Dukelow and Hein say.

Parents want their children to have the best possible program of physical and health education, yet many reject the facts derived from exhaustive study of children. This is because parents "prefer to bask in the reflected glory heaped upon immature children by an unthinking public which demands the last ounce of effort to win for good old X Junior High School". Actually, instead of the chosen few on the team, physical education in schools should stress a well-rounded program of instruction for all children, and, for as many as possible, an interesting, extensive program of intramural competition in team, dual and individual sports. This should be supplemented by sports days and play days.

The country's leading educational and medical groups have recommended that "interscholastic leagues should be confined to senior high schools. Interschool activities for junior high school pupils should be limited to occasional meets or games. Junior high school boys should not compete in American football. An extensive program of intramural activities is strongly recommended for these students."

* Abstracted from the November 1951 issue of *Today's Health.*

REHABILITATION OF THE AGED CHRONIC INVALID

Joseph O. Smigel, M.D.,* Pinewald, N. J.

In increasing numbers, physicians are seeking an answer to the problem of making the aged handicapped of some further use to society, or, failing that, of some usefulness to themselves. And, in increasing numbers, they are succeeding. The example set by the Institute of Physical Medicine and Rehabilitation of New York University Bellevue Medical Center has focused the eyes of other large institutions on their methods, organization and system of evaluation clinics. But this pattern does not readily lend itself in its entirety to smaller groups, where modifications can still give commensurate results if the will be there and the know-how of applying knowledge of physical medicine can be brought to bear.

One New Jersey nursing home now with a capacity of 260 beds, has, since April 1950, been largely devoting its time and attention to the aging patient. Since the sanitarium is privately staffed, evaluation had to become compact. Decisions were made by a three man team after needed laboratory and physical examinations had been gathered and the social worker had secured background values and story. Usually the medical director, physical therapist rehabilitation director and resident called in a member of the nursing department for opinion and intimate questioning as to attitudes and responses and/or the social service director as to her findings on familial stimulation or inhibitions, or other relevant altering factors. Essentially, it was found that with the patient alone must lie the final answer as to whether he will help himself again or whether he will be happy in complacent uselessness. If willingness to assume a useful life is ascertained, it becomes a matter of determining how strenuous a rehabilitation course can be inaugurated and what goal should be sought.

X-ray and fluoroscope, reliable laboratory reports, electrocardiograms, a knowledge of exercise tolerance, and ability to evaluate muscle and nerve responses, are the minimal requirements. Surprisingly, perhaps, the maximal requirements do not add much more value despite their complicated approach and great increase in cost. The process resolves itself thereafter into a determination of:

(1) What capacities has the geriatric patient lost?
(2) What capacities has the disabled aged left?
(3) What can be done to make collateral capacities replace those lost?

Each case is treated on the basis of exploiting whatever capabilities exist, and of abating or circumventing whatever handicaps have developed. This is a general principle in all rehabilitative care, but unfortunately it is all too often lost sight of when the aged are involved.

Rehabilitation in some form or other is a concomitant of nursing care in all patients admitted to the Sanitarium. In this broad sense, however, there is a tendency for the picture to become distorted. The objective is then the much more easily attainable one of rescuing the aged invalid from idleness and of making provisions for the use of such capabilities as he retains, for the primary purpose of maintaining his interest in life, through proper guidance of means to occupy his long stretches of leisure time.

For the purpose of this paper, we will consider only those patients who were found potentially capable of active intensive treatment by the use of physical medicine, and have been discharged. Twenty-five others are at present undergoing treatment.

From April 6, 1950, to January 6, 1952, (a period of 21 months) 149 patients, aged 60 or over, were discharged from our rehabilitation department. Average age of the discharged group was 75.3 years at the inception of treatment. Of these, 15 died of intercurrent disease or of recurrence of the original disabling condition, usually cardiovascular. Fourteen were removed before treatment was completed. Understandably, the largest group were 60 hemiplegics (40 per cent), and the next most numerous were the 20 fractures (14 per cent). Fifteen of the discharged pa-

* Medical Director—Pinehaven Sanitarium, Pinewald, N. J.

tients returned to their own or their children's homes to a life of usefulness in their family or business; and an additional 49 were able to take care of themselves to such an extent that their families could keep them at home without the fear of having them again become the burden which had initially been largely responsible for their institutional placement. Of the 120 who were discharged by the department, 64 (or 53 per cent) were materially helped, while of the remaining 56, none had less than a 10 per cent improvement

The important factor, insofar as the small hospital, clinic group practice unit, or even general practitioner is concerned, lies in the fact that no modality has been used that is not readily available to the private physician, with the sole exception of the full body agitation tank.

The factor most instrumental in bringing success to the patient and to the rehabilitation group was the persistent continuous day-in and day-out treatment. The second most important instrument for success in rehabilitation of our patients, lay in giving each patient the maximum amount of exercise within his range of tolerance, and trying to increase his tolerance as rapidly as possible with no more assistance from the therapist than was absolutely needed.

Diathermy was used to produce deep relaxation, where spasticity was present, relieve deep pains and give transitory circulatory stimulation.

Infra-red was used in much the same manner for the more superficially involved conditions or parts.

Hot packs and dry heat have their specific fields of greatest effectiveness. In all heat treatment used for the hemiplegic, care must be taken to avoid injury to the skin. These patients are often deficient in their sensory appreciation of heat and may easily be burned.

Galvanic, faradic and sinewave therapy have been used in delayed cases to show the so-called "hopeless invalid" that movement was still possible in the affected part, and to institute rhythmic motion.

Mecholyl[1] *and magnesium sulphate iontophoresis* was found useful for the relief of pain and concomitant tension in arthritics and in some vascular disturbances.

Small and medium whirlpool baths have been used to great advantage in fracture cases. Sprains and local swellings respond readily to these measures.

The *whole body agitation tank,* in the early stages of hemiplegia, has been found without peer.

Intermittent vascular constriction was begun late in the course of this evaluation. Usually, 45 millimeters of mercury pressure was used at the beginning and gradually raised, but never beyond 60 millimeters. The time was for 30 minutes at the start, up to 45 minutes, twice a day, two minutes on and two minutes off. Results have been markedly beneficial in chosen peripheral-vascular diseases, especially in deep chronic and indolent ulcers—varicose or other—of the lower extremities. The use of Mecholyl[1] in association with vascular constriction is too recent with us for present evaluation.

The *mat,* the *roller skate* placed on the outer floorside of the foot, the *finger exerciser,* the *wheel,* the *pulleys,* all have their place. *Passive manipulation* of the extremities (to bring out a complete range of motion of all joints) is important to prevent contractures and avoid arthritic and soft tissue changes, based mainly on enervation and loss of nutrition to the part. But none compares with the *parallel bars* for retraining, or with the body tank. These two together have been the mainstay of our regimen.

Supportive apparatus (braces, canes, crutches, pulleys, walkers, wheelchairs) can be continued too long. They then become a deterrent to recovery, instead of an aid.

Devices used to ease the way to normal group living have a definite place in bringing assurance, but they too can be continued too long and, at times, their introduction reacts unfavorably. They emphasize a hopelessness of end results, which may not be indicated at all.

Since these people were old (averaging 75.3 years) the score cards ordinarily used in determining the percentage of recovery, with

1. Mecholyl is the Merck Company's tradename for their brand of acetyl methyl choline.

tests such as climbing up three flights of stairs or opening windows, et cetera, were not considered adequate, for the needs of this age group. Even on these score pads, the degree of recovery of functional use came to 40 per cent.

A more practical method of scoring was necessary. These people were, for the most part, not required to do things for others, or to work for a wage. The criterion then became, "What can the patient do for himself that he was not able to do previously?" Whether he can button his clothes becomes an extremely important item in a man's life after a paralyzing stroke. Can she comb her hair? Can he again shave himself? Can he manage to get to the bathroom without help? Can he hold up a hand of cards and keep himself entertained with his companions? These criteria have vastly greater meaning to the recovering fracture patient, or hemiplegic, than "Can he lift the window?", which he will hardly be called on to do. To him, this measure of improvement means he can live and like it. By this standard, the average of surviving cases represents 75 per cent improvement.

Training in gait—getting in and out of a chair by himself—feeding himself without sloppiness, walking steps, going to the bathroom alone, dressing himself, are measures that are extremely satisfactory in their attainment.

Inherent in the care of the aged is the axiom that treatment should not be given up merely because total cure cannot be attained. The value of salvaging what remains is shown by some of the reported cases.

CASE ONE

A 66 year old woman arrived in a wheelchair by ambulance with extensive ulcers of both legs, due to an old injury. She had been in and out of hospitals with these, and secondary infections and osteomyelitis, for years. Ulcers covered the entire lower third of each leg, girdling the legs irregularly and being more extensive posteriorly. The greatest breadth was 8 inches; the narrowest, 4 inches wide. The slough and debris were necrotic and foul. At one time, in the course of her pre-admission treatments, the use of a crutch had been attempted, with a resulting radial paralysis of the left hand.

Heat cradle was applied continuously for 24 hours a day up to the 35th day after admission, when new skin formation was in evidence. The dry heat treatment was thereafter interrupted twice a day for increasing periods of passive exercises of the part. On the 79th day the dry heat was discontinued; weight bearing and ambulation were started. The area of ulceration had been diminished by more than one-third in each leg by this time. The patient progressed through parallel bars. Crutch walking was not attempted, since the previous attempt (before admission) had caused paralysis of the left hand. This paralysis was being treated by diathermy and whirlpool bath. The patient progressed through the parallel bars directly to two canes and then to one cane walking. Seven months after admission, she re-infected herself and continuous wet antiseptic dressings were applied for four months with occasional resort to the dry heat. By this time, the entire right leg was healed over with skin and scar formation; the left, however, resisted further improvement.

Fourteen months after admission, intermittent vascular constriction was begun twice daily, 2 minutes on and 2 minutes off, with up to 60 millimeters of mercury, starting for 20 minutes and increasing up to 45 minutes. At present, granulation and new skin formation has appeared throughout the remains of the ulcerated area on the left leg. The patient is fully ambulatory, though she uses the cane occasionally, can use her hands, and is fully able to take care of herself.

CASE TWO

A 68 year old woman was admitted on April 8, 1950, with incontinence of bladder and bowels, cerebral arteriosclerosis and hypertension. Blood pressure was 218/140. Within 48 hours of admission, she became disoriented, went into coma—which lasted for 5 days—and finally settled into a right hemiplegia, with facial distortion and aphasia. Speech returned slowly and was guided without forcing any issue with the patient, but giving constant assurance.

Recumbent muscle re-education was inaugurated in bed, by passive and then mild resistance exercises of gradual increasing tempo. Rapid improvement ensued, and she was taken down to the physical therapy room for parallel bar walking, then crutch and cane walking. By June 1, she was walking with a cane, though her right foot dragged. The right upper extremity, though showing some power in shoulder and arm, was not responding as rapidly as had been expected. Whirlpool treatment for the arm and shoulder was instituted and resistance exercises outlined and systematically applied. In October 1950, severe hip pains intervened, which were quickly dissipated by diathermy. The patient now walks miles, has full use of upper and lower extremities, her speech is fully understandable, though it still slurs somewhat, and her blood pressure stays at a constant 170/110.

CASE THREE

An 82 year old woman was admitted on August 8, 1950, by stretcher, with arthritis of the right knee, arteriosclerosis, hypertensive heart disease and malnutrition. She had a history of arthritis

of the right knee and foot, following a "stroke" on July 1, 1950. In August, she was told she "had only one chance in a million of ever walking again". The emotional shock of this blunt announcement appreciably aggravated her handicap.

Mild electric stimulation assured her that she *could* move her legs. She was immediately put on passive and resistance exercises while in bed, until she was entirely sure she could move her legs of her own accord. As soon as we felt she might be able to get about, a shoe, with lift, was provided to compensate for the slight difference in length between the legs. Thereafter, she progressed through parallel bars, crutch walking, double canes and the use of a single cane. Diathermy to the knee and foot were adjuncts to the treatment.

At the time of her discharge on November 5, 1950, she was capable of walking alone without the use of any cane, though it was thought advisable that (because of her age and residual malnutrition) she had best continue to use the cane. The follow-up report on her in January 1952, shows her active and "full of life".

CASE FOUR

An 80 year old man was admitted on July 21, 1950, with a blood pressure of 170/80, a diagnosis of generalized arteriosclerosis, and deep, painful, indolent ulcers about 2 inches in diameter on both heels. These had been present for the past 7 years. The ulcers were foul and sloughing. The feet and legs were swollen.

Elevation of the legs relieved the pain and aseptic measures quickly reduced the swelling. No great progress, however, was made in reducing the ulcerated area until August 13, 1951, when intermittent vascular constriction, 2 minutes on and 2 minutes off (pressure, 50 millimeters of mercury) was begun, and the ulcers were completely filled in and healed by November 1951.

CASE FIVE

A 60 year old woman was admitted on May 27, 1950, she was emaciated and weak, she had had a "stroke" in November 1949, after which she developed melena and loss of control of anal sphincter, and resultant diarrhea, since March 1950. She was admitted with a blood pressure of 223/150, a mass in the right abdomen, dehydration, auricular fibrillation and melena. The diarrhea and melena were controlled with phthalyl sulfacetamide.[2] An opiate which she had been using for nearly a year, was discontinued within two weeks. Her apprehension having by this time subsided, physical therapy was started, with exercises in bed, and then in wheelchair. When she was able to get to the physical therapy room, a short leg brace was fitted and she was instructed in the use of the walker, instead of the wheelchair. She progressed rapidly through the parallel bars and cane walking, and was discharged on July 8, 1950, against our advice. Her hypertension was still marked. She is living with her daughter, and does light housework for herself and her daughter.

Pinehaven Sanitarium

BRAIN ANOXIA

REPORT OF A CASE

Felix Frisch, M.D., Trenton, N. J.

One afternoon in 1950, a 19 year old man was driving a small truck which was struck by a speeding train. The driver was thrown out of the car and fell into an adjacent canal where he lay prone, his head and trunk submerged, his feet planted on the bank of the canal. When he was hurled out he must have hit his head on the roof of the car, for he was bleeding profusely from the head. He was lying motionless until rescued from the water. Although the accident was observed by nearby witnesses, it was *five minutes* before they reached the victim and succeeded in extricating him.

The man was not breathing, had a dark blue color of the face and hands and, of course, was deeply comatose. One rescuer immediately applied artificial respiration and placed the patient shortly afterwards in a respirator fetched from a fire station in the vicinity. Still in the respirator he was brought to a hospital where he remained unconscious for ten days. He gradually regained consciousness. No fracture of the skull was found. Urine, first collected by catheter, was hemorrhagic and the whole lumbar region was discolored.

Ten months after the accident, I had occasion to examine him. Neurologic and psychiatric findings then were:

(1) *Complete amnesia* for the whole occurrence. Actually, the amnesia was also *retrograde* since he was unable to recollect the

2. In the form of Thalamyd—the Schering Corporation tradename for their brand of phthalyl sulfacetamide.

happenings immediately *preceding* the accident.

(2) When insistently asked to explain why he was at that place, he filled in the memory gap with confabulations: the characteristic picture of a Korsakoff's syndrome; though, in this case, a traumatic rather than an alcoholic Korsakoff's syndrome.

(3) His narration was confused; sentences were never finished, always interrupted by incoherent thoughts.

(4) The most conspicuous symptom was his markedly disturbed *memory*. The retention of recent material was severely impaired.

(5) *Change of personality:* He has become extremely irritable, has constant arguments with relatives and friends; he was easily irritated during the medical exploration. He quickly tired when trying to concentrate.

(6) A positive electro-encephalogram: Dysrhythmia, many episodes of fast low voltage discharges and series of slow waves, at four per second.

(7) A moderate right sided hemiparesis without involvement of the reflexes.

The first question which suggests itself to a physician is: How could this man survive? Having been submerged for five minutes he should have been drowned even when only superficially breathing. The fact that he did not drown means that respiration completely stopped, apparently due to the severe "shock" and concussion. The apnea, we have to assume, saved the man's life.

However, among the many problems which this case offers for physiopathologic consideration only one need be discussed here: the fact that the oxygen supply of the tissue had been abolished for five minutes. It is known from clinical-pathologic as well as from experimental evidence that among the various organs and tissues, the nervous system is the one most sensitive to anoxia. The highest degree of sensitivity is shown by the cells of the "association area", i.e. the uppermost three layers of the cortex (supragranular laminae of the cerebral cortex). Insufficient oxidation of these cells stimulates functional activity and produces the following severe changes. Intracellular acidity rapidly increases with consequent swelling and rupture of the involved cells, the cytoplasm is destroyed and the fluid disappears. "The rapidity with which severe anoxemia is produced is the most important factor in the severity, nature and distribution of lesions in the nervous system." *(Chornyak)*[1]

The clinical deficiencies which our patient presented are in perfect conformity with the expected pathologic changes particularly the associative function, the impaired memory, the changes of personality, and mental fatigability. The electro-encephalogram demonstrates the cortical damage which is irreversible and enduring.

740 West State Street

THE NEW JERSEY DERMATOLOGICAL SOCIETY

With the final reading and adoption of the revised constitution on February 5, 1952, the New Jersey Dermatological Society formally came into existence, succeeding the Northern New Jersey Dermatological Society which was founded in 1935. The first president of the new organization is Dr. Morris H. Saffron of Passaic. Present membership is 65. Meetings are held five time a year at the Academy of Medicine in Newark and are open to all physicians. Although regular membership is now restricted to full-time dermatologists, the constitution provides for associate membership which is open to all physicians seriously interested in dermatology. Requests for further information may be addressed to the Secretary, Dr. Frederick C. Licks, 64 Scotland Road, South Orange, New Jersey.

1. John Chornyak: Pathogenesis of Structural Changes in Central Nervous System Produced by Anoxemia. Bull. U. S. Army M. Dept. 8:695 (Sept. 1948).

A METHOD OF PSYCHOTHERAPY FOR THE GENERAL PRACTITIONER

J. Chernus, M.D., Newark, N. J.

Within the last several years, physicians in general practice have been so assiduously exhorted from all sides to practice psychotherapy, that, regardless of personal inclinations, many have attempted it. From what I have seen and heard, the results could have been better for the patient, and the efforts have been taxing and discouraging to the physician.

This result cannot be attributed to academic lack on the part of the writers, nor to any unsoundness of the principles of psychotherapy. The difficulty stems from the fact that the problem has not been approached from the point of view of the general practitioner. In the various publications on the technic of psychotherapy, the physician has these two choices suggested to him: (a) Do a thorough physical examination, and then assure the patient sympathetically that there is no organic disease, or (b) Go a step farther, and suggest to the patient that there must be an emotional basis for his symptoms, and ask the patient if he would care to take up with the doctor his emotional conflicts. The first technic is relatively easy for the doctor. All he has to learn are some carefully chosen phrases, to avoid giving the patient the feeling that his doctor regards the symptoms as "imaginary", or that he is a "mental case". This method is also efficacious for the patient.

The drawback is that the effect is too transitory. Within a few days the patient is back for another examination. The repetition of the process soon exhausts the emotional equanimity of the average physician; resentment and intolerance of the patient is then almost inevitable. At this point, the doctor yearns for the existence of a "nice, juicy" pathologic condition, with which he could grapple. And the wish could become the father of the fact.

The drawback in the second technic is even greater. It has been generally overlooked that, in effect, this demands that the physician baldly announce "Your trouble is emotional, not physical. You need psychiatric help; let's start on it right now." That this pronouncement is literally true, does not mitigate the difficulty. Every physician knows how hard it is to refer a patient to a psychiatrist. It is no easier to refer the same patient to himself as the psychiatrist. Even if the patient accepts this arrangement, there is the physician to consider. Having, as it were, "shot his bolt" as an "organic" physician (a role to which he is accustomed and in which he is comfortable) he now has to assume a strange and unfamiliar role. He is urged in the publications never to turn back on his decision, never to reexamine the patient, give diathermy or injections.

But every experienced psychiatrist knows how tenaciously the patient clings to somatic symptoms, and how resistant the patient is to see his unconscious feelings and conflicts, the myriad of maneuvers the patient devises to throw the psychotherapist off the track. This is true even when the patient asks for psychotherapy, and is ostensibly eager to delve into his own psyche. Small wonder then, that the average physician, unskilled in the finer nuances of managing resistances, is soon thrown on the defensive by the skillful maneuvering of the patient, and seeks a way out of his uncomfortable position by returning to a somatic orientation.

I would like to suggest a scheme of psychotherapy which obviates the above enumerated difficulties. But it involves a calculated risk. Every physician seems to be haunted by a fear of making a "functional" diagnosis, when all the time the patient was suffering from an organic illness. It seems as if no greater professional sin could be committed, and the physician guilty of it is to be jeered at by his colleagues for the rest of his days. The opposite kind of sin, the consignment, say, of a patient to inactivity for years because of a supposed heart disease (when all the time he was suffering from psychoneurosis) seems to be no sin at all, and is easily forgiven by understanding colleagues. It is beyond the scope

of this paper to attempt an explanation of this phenomenon. In my opinion, the risk alluded to is negligible. I bring it up only as a concession to physicians who are bound to raise the bogey of "just talking" while all the time the patient was suffering from a serious organic illness.

The essence of the technic I suggest is that the patient verbalize meaningful and relevant emotional material *without being aware that he is doing so.* This can happen only if the patient thinks he is talking to a friendly, sympathetic "organic" physician.

The moment the physician openly changes his role from "organic" to "psychiatric", the patient's defenses and resistances immediately come into play. The "trick", therefore is to maintain the impression (in the patient) that he is being viewed "organically", while at the same time, the physician can reassure himself that he has not "missed the boat" on some organic condition, and the patient is, in fact, suffering from a neurosis.

To perform this admittedly difficult maneuver, the physician greets the patient in a friendly, interested manner, but avoids stilted overzealousness. The consulting room should be comfortable, but not "Hollywoodish". It should be quiet and free of extraneous noise, or intrusions by secretary or nurse. The doctor should appear unhurried and attentive. It is preferable not to write while the patient is talking, except when absolutely necessary to record an easily forgotten detail. It is better to jot down material from memory after the patient leaves. The key to success is to elicit material from the patient by an air of attentive listening. So long as the patient talks, it is better not to interrupt. The doctor should appear interested, even if he regards the material as valueless. In the event of a pause, only questions of a general nature should be used to get the patient started again—"tell me as much as you can about your trouble", "how does it make you feel?". Especially useful are the questions "how does it interfere with your daily life?" and "what is your hunch about the nature of your trouble?". The patient should be allowed free expression for a minimum of twenty minutes. The doctor should listen particularly for material pertaining to domestic life, work situation, and significant people in the patient's orbit. The patient should not be cut off abruptly. At a suitable pause, the doctor may say—"I'll begin my examination now. I like to get a very thorough history, but we will have to defer it until your next visit because of time limitation". Such a phrasing, tactfully said, gives the patient the necessary "out". He is "safe" in talking because however "psychiatric" the material may be, the patient has been beguiled into considering it as "medical" history.

At this point the physician must take the calculated risk. If he is haunted by the fear of missing an organic condition, his fear will compel him to launch into an exhaustive physical and laboratory examination. The patient will sense this, and expect from the doctor a final statement as to diagnosis. The doctor can only (a) tell the patient that there is no organic disorder, or (b) invite discussion of emotional conflicts.

If the doctor's clinical experience has taught him that in many patients such an exhaustive physical study yields negative results, he may want to risk doing a five minute examination, which will at least rule out the existence of gross, acute organic disease. Then he is in a strategic position. His mind is relatively unclouded with the specter of organic disease.* To the patient he can say, "I have done the first part of my examination. I can assure you that there is no acute urgent condition threatening you. The rest of the examination will take more time, and may have to be spaced out over several visits." An appointment should be made for the next visit, five to seven days later. In essence, what the doctor does is to stall for time against the day when the patient legitimately demands a diagnostic reckoning. If he maneuvers astutely, the physician, on that day, will have material from the patient's own mouth to explain his condition to him. In short, the aim is not to rely on negative physical findings to support the diagnosis of neurosis, and then suggest investigation of its emotional origins, but in-

* Dear Doctor Chernus: He *might* have a carcinoma of the stomach. Should the doctor's mind be "unclouded" after a 5-minute examination?—Editor.

stead to base the diagnosis on "positive" findings—from the patient's own material.

If the patient keeps the next appointment, the doctor can be sure that some degree of improvement from psychotherapy is possible. If he does not keep the appointment it means either that the doctor did not develop a genuinely "accepting" attitude to the patient, or that the patient is not amenable to psychotherapy.

At the second visit, the physician should again assume a receptive listening attitude. Careful note should be made whether the patient repeats the same complaints, in a stereotyped manner, as on the initial visit. If so, it is an indication that the neurotic condition is well entrenched, and will not yield readily. If, however, the patient presents new symptoms, or the former symptoms, slanted in a new way, invested with considerable emotional tone, the outlook is better. So long as free flow of material obtains, the doctor should listen. If symptoms are harped on, the doctor should ask for a detailed description of the worst period of subjective distress during the interval since the initial visit. This affords an excellent opportunity to understand the *meaning* of the symptoms, if the doctor will listen critically for hints as to the important people or situations which serve as the setting for the symptoms. After thus reviewing the past week, the physician should begin the so-called "past health history".

What the doctor is really eliciting is the history of past adaptations to the emotional stresses of life. But clothed under the euphemism of "health history", the physician has a chance to get a "candid camera" snapshot of his patient as against the "posed" picture he would get if he were to ask directly for a review of the patient's emotional life history. The fine point of the technic is not to gather information as to illnesses, according to a check list. The idea is to read between the lines, to give a little subtle suggestion here and there which will unobtrusively steer the patient into an anamnesis. One should steadfastly inquire into subjective manifestations. Statements such as "I had appendicitis", "I was sick with anemia" (run down, bad heart, et cetera) should be met with—"Tell me about it—what symptoms did you experience, how did it make you feel? In what way did it interfere with your life?"

Again, after about twenty minutes, the physician should tactfully bring the "talking session" to an end with an innocuous remark. He can then resume the examination with a blood count, fluoroscopy, or electrocardiogram. Once again, he should say: "There is no change from the last time. There is no sign of any acute condition which threatens you, and I am certain you will be all right. When I see you next time I have some further examinations to make."

On the third visit, the history of health in childhood is started. This is an excellent opportunity to study the patient's childhood emotional patterns. When the "past health history" approach seems to have been used up, a new lode, equally rewarding, is opened with the "family health history". Here again, the categorical listing of diseases of various members of the family is of relatively little interest. Subtle leads, such as: "Was your father a healthy man? What kind of work did he do? What kind of a father would you say he was?" —will gently steer the patient into relevant productions. The same leads apply to mother. Other useful leads are: "How did your health compare with that of your brothers and sisters? How did your parents react to your being sick? Tell me about your health in the first school years, and now the later years in school, the first years of your work career."

How far should the doctor pursue this course? Here is a good rule of thumb—if you were writing a novel, have you got enough from the patient's own material to describe him as a credible, understandable person in your novel? Could you write a paragraph about your patient, which would set forth the essential "human interest" facts of his biography? Viewed from another angle, can you rate your patient, as he is today, on this scale: ability to regard himself as healthy, capacity to work and be creative, capacity to love—friends, family, and love for the opposite sex, capacity to mobilize adequate socially mature

aggression and self-assertiveness, capacity to develop adequate self-esteem. Can you list his assets and shortcomings?

If the doctor knows his patient to this extent, and *has assured himself that he has no organic disease,* he is in a strong position therapeutically. He can say to the patient—"there is absolutely no organic disease in any of your organs or systems. However, a human being is more than a collection of organs. I have gleaned something of your structure and development as a human being from our review of your health and family health history. The trouble might be there—in your emotional functioning as a human being."

This is solid ground. If the patient stops treatment at this point, he has more than the intellectual assurance that there is no organic disease. He has had emotional catharsis in this technic, and he will not come back in a few days, for a re-affirmation of the assurance. If the patient elects to continue treatment, the doctor can legitimately ask that the mask of somatic symptoms be dropped. It is then that a good deal of fresh material about his current life situation emerges. If there is no direct reference to sexual function, the doctor is now in a secure enough position to inquire directly about it.

Now the doctor can do more "active" psychotherapy. He can point out to the patient, from his own material, how his personality structure has developed its characteristic modes of adaptation and defenses against stress. Moreover, he can explain to the patient what precipitated the present illness. He can then implement the tools of superficial therapy—persuasion, assurance, explanation how emotions express themselves in part through somatic channels. Deeper therapy involves relieving guilt feelings, the encouragement to soften rigid attitudes and standards, and direct advice on how to cope with certain emotional conflicts. However, the doctor should never advise marriage, divorce, or separation — no matter how common-sense these steps may appear. Advice on recreational, social and vocational matters is permissible when indicated. As a general rule, as little advice as necessary should be given, since it fosters dependence.

The novice in psychotherapy should bear this in mind: the patient under the spell of the positive interest of the physician, may rapidly lose his symptoms, while at the same time he becomes quite attached to the therapist. This "sticky" attachment should be anticipated and forestalled. This is done by constantly encouraging the patient to assume responsibility for his own decisions and plans for happiness. The interval between appointments should be gradually increased. Sometimes it is advisable to agree on a date when the sessions will end, and the patient will have to get along by himself after that date.

The method of psychotherapy suggested herein has many shortcomings. However, for the general practitioner, who does not have the opportunity to learn psychotherapy under direct supervision, it is a useful elementary method to start self-training, from which he can go on to learn more complex technics.

61 Lincoln Park

THE MISUNDERSTOOD DOCTOR

All over the country, grievance committees report that most complaints involve fees. Some are legitimate gripes about exhorbitant fees. But most arise from misunderstanding. Patients should be encouraged to discuss medical services and fees with their doctors. The American Medical Association now makes available, as a service to members, an attractive office plaque designed to stimulate discussions regarding fees and problems of medical care. Order a plaque for your office today from the Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. The price is one dollar.

SCABIES EPIDEMIC IN AN INSTITUTION

HARRY C. GOLDBERG, M.D., Plainfield, N. J.

A wide-spread out-break of an itchy skin condition in a large nursing home became severe enough to require special medical attention. For a number of months prior to that time, several remedies had been used with indifferent results. Among these was a widely advertised proprietary drug used for scabies. About one fourth of the patients seen at this time had considerable involvement of the skin, another fourth had suggestive lesions in which scabies would probably not have been considered ordinarily. The remainder of the patients had no definite lesions nor complaints.

Scabies has been known for thousands of years and for hundreds of years the cause has been known to be a mite. This is known as Sarcoptes scabei, Acarus scabei, and other synonyms. In the fourteenth century Guy de Chaulic mentioned that it burrows into the skin. Mouffet in 1634 accurately described the organism which burrows into the skin and there deposits its eggs. The ova develops into larva in about ten days. The larva matures in three to six days, grows in size and crawls to the mouth of the burrow. As it requires one to two weeks for a burrow to form, and several weeks before the production of new ones, every early case of scabies must be regarded as at least six weeks to three months old.

The burrow is the characteristic lesion in scabies. It contains the mite.

Various methods are described for isolating the mite. In general they are cumbersome, and often fail to find the organism even when it is present. The organism is present at the larger end of the burrow where the mite is actively burrowing and irritating the skin. Therefore this is the part of the burrow in which to seek the mite. The British described a simple and effective way to root out and examine the mite. A straight cutting edge or triangular needle is inserted into the larger end of the burrow and the top is laid open. The organism, a clearly seen oval speck about 0.4 mm in size, will be found to adhere to the needle point when the needle point is raised from the burrow. It is readily transferred to a glass slide and directly and easily identified as a moving, crab-shaped organism.

Kaposi[1] stated in 1895: "In our city scabies is most frequent in those trades in which the apprentices sleep two in a bed. The shoemakers and the tailors furnish most of the cases. About twelve hundred cases are treated yearly in our dermatology department."

In Egypt[2] animal scabies is common. This is probably so in other countries as well. The usual sources are camels, cats and cattle. It is differentiated from human scabies by the absence of burrows, the localization of the lesions depending on the mode of contact with the source.

Usually prolonged contact is required for the disease to be contracted, but it is occasionally picked up by doctors and nurses, or as in the case under discussion, in an institution where contact may not be long but is frequent, and ample opportunity for transfer of the mite is created. Here it was thought that a newly employed nurse was infected and the source of the spread of the disease.

Examination of the extensively involved patients showed surprisingly few places on only a few patients which could be considered as typical burrows suitable for scraping and examination for the scabies organism. The organism was found and a positive diagnosis of scabies was made in two patients.

Two private patients were seen who had contact with one of the infected patients in the nursing home. Both of these had little or no involvement of the classic areas usually found in scabies such as the genitalia, breasts, wrists, interdigital spaces, anterior axillary folds, and buttocks. The only visible lesions were excoriations of the lower abdomen and thighs. After treatment with various scabicides is completed it can often require surprisingly long periods of time for the eczematized areas to heal. Probably part of this is

1. Kaposi, Moriz: *Diseases of the Skin*, William Wood and Company, 1895, page 650.
2. Mikhail, G., Rizk and Falk, Mortimer S.: *Dermatology in Egypt;* Arch. Dermat and Syph., 65:21 (January 1952).

due to the foreign body reaction to dead parasites, ova and feces left in the skin and this reaction persists till these elements are exfoliated. In the axillae, on the buttocks, on the penis, and the scrotum large indurated nodules develop which can persist for months. If a second course of treatment seems necessary, it would be wise to use a different scabicide to avoid an allergic reaction to an acquired sensitization of the first scabicide. But this should not be repeated unless symptoms persist for more than two weeks after the first treatment has been given, and then only after the irritating effects of the scabicide has worn off. Immediately after the active treatment, a bland cream or lotion should be used until the skin feels comfortable.

The present outbreak of scabies occurred in a nursing home of sixty patients. Of these, thirty had skin lesions, which were felt to be due to scabies. Of these thirty, skin scrapings were positive for the mite in only two, but in the remaining twenty-eight the contact history and clinical appearance of the lesions were considered sufficient for the establishment of the diagnosis.

It was decided after the diagnosis was made in this institution that all patients and employees should be treated to stamp out the disease. Since it was necessary for most of these elderly patients to have the treatment given by the nursing staff, it was decided to use a preparation which could be applied most easily. Kwell[4] was used for this purpose. It was applied twice at twenty-four hour intervals. The patients with mild infections did well with this agent. Of the more severely involved patients two developed considerable irritation. Two who seemed to have possible residual infection were later treated with mild five per cent sulphur ointment for three days.

A frequent complication of scabies is impetigo, especially involving the face.[3] It is important to recognize this and not rule out scabies because of involvement of the skin in this area, which is not part of the usual scabies distribution. The impetiginized lesions respond rapidly to the antibiotic and sulfa drugs.

SUMMARY

Scabies in epidemic proportion as in an institution is readily diagnosed and follows the text-book picture but treatment is difficult because of re-infections among patients. Scabies in the average private patient is difficult to diagnose positively, but is easily and effectively treated. A therapeutic trial of a scabicide is readily carried out in persistent intractable dermatoses where scabies may be suspected.

7 Watchung Avenue

COURSES IN LABORATORY DIAGNOSIS OF TUBERCULOSIS

In cooperation with the Division of Chronic Diseases and Tuberculosis, Public Health Service, the Bacteriology Laboratories of the Communicable Disease Center, Chamblee, Georgia, will offer courses in the laboratory diagnosis of tuberculosis.

Two courses will be given for laboratory directors, senior laboratory staff members, physicians, and others of comparable professional standing on May 19 to 23, 1952, and on November 3 to 7, 1952.

The courses are also open to all laboratory personnel who are approved by their state health officers. Practical laboratory training in all phases of tuberculosis bacteriology, including preparation of culture media, microscopy, cultural procedures, diagnostic use of animals, and testing of drug sensitivity will be included in the course. No tuition or laboratory fees are charged. Reservations for the courses should be made well in advance. The dates of these technician courses are April 14 to 25, 1952, and again on November 10 to 21, 1952.

Additional information and applications may be obtained from the Officer in Charge, Public Health Service, P. O. Box 185, Chamblee, Georgia.

3. Highman, W. J.: *Dermatology*, Macmillan Company, 1921, page 225.
4. This is a brand of a 1% cream of Benzene Hexachloride in a vanishing cream base. It is trade-named by the pharmaceutic division of the Commercial Solvents Corp. of New York.

Medical-Surgical Plan of New Jersey
"New Jersey's Blue Shield Plan"

COUNTY MEDICAL SOCIETY ADVISORY COMMITTEES TO MEDICAL-SURGICAL PLAN OF NEW JERSEY

Medical-Surgical Plan has recently completed a series of four regional meetings with the members of the advisory committees to the Plan from the various county medical societies. These committees were appointed by the Plan in November 1951, the personnel of each such committee having been nominated or recommended to the Plan by the president of the county medical society.

Fifty members, representing 19 of the 21 county committees were present during the initial series of conferences, held between January 30 and February 20, 1952. These conferences were arranged for several purposes. First, they gave the medical and administrative representatives of the Plan a chance to get acquainted with members of the advisory committees from all parts of the state; second, the meetings enabled the Plan to obtain the opinions and advice of a cross-section of representative physicians relative to certain problems facing the Plan; third, and perhaps most important, these meetings established a new, two-way avenue of communication between the Plan and the medical profession throughout the state.

The Plan looks upon the members of its advisory committees as the ambassadors of the physicians practicing in their respective counties. We should like to suggest to each Participating Physician that if he has any suggestion for the improvement of the Plan, or any request for clarification of Plan policies, he should not only communicate directly with the Plan, but should also discuss his ideas or suggestions with members of the advisory committee for his own county.

For the information of all physicians, we here list the members of the county medical society advisory committees to Medical-Surgical Plan:

County

Atlantic—James F. Gleason, M.D., *Chairman*
Daniel Wilner, M.D.
Charles Saseen, M.D.

Bergen—Rudolph C. Schretzmann. M.D., *Chairman*
Luke A. Mulligan, M.D.
Howard J. Rosenbauer, M.D.

Burlington—J. Howard Hornberger, M.D., *Chairman*
E. Warren Rodman, M.D.
Bernard Leonard, M.D.

Camden—Harold K. Eynon, M.D., *Chairman*
Oram R. Kline, M.D.
Philip D. Gilbert, M.D.

Cape May—J. S. D. Eisenhower, M.D., *Chairman*
Herschel Pettit, M.D.
Carl J. Records, M.D.

Cumberland—A. B. Kump, M.D., *Chairman*
Charles M. Gray, M.D.
L. J. Kauffmann, M.D.

Essex—J. I. Echikson, M.D., *Chairman*
F. S. Forte, M.D.
W. H. Hahn, M.D.
C. G. Matheke, Sr., M.D.

Gloucester—B. A. Livengood, M.D., *Chairman*
J. J. Laurusonis, M.D.
C. C. Sheets, M.D.

Hudson—William J. Gleeson, M.D., *Chairman*
Executive Committee

Hunterdon—John Fritz, M.D., *Chairman*
Arthur M. Jenkins, M.D.

Mercer—P. J. Warter, M.D., *Chairman*
John Preece, M.D.
John F. Kustrup, M.D.
Guy K. Dean, M.D.

Middlesex—William G. Kuhn, M.D., *Chairman*
George Henderson, M.D.
Philip Mangogna, M.D.
Benjamin Copleman, M.D.

Monmouth—Louis F. Albright, M.D., *Chairman*
Samuel Edelson, M.D.
James P. Pregnall, M.D.
Joseph F. Raffetto, M.D.

Morris—W. F. Costello, M.D., *Chairman*
Earl D. Stage, M.D.
G. H. Laudig, M.D.

Ocean—Raymond A. Taylor, M.D., *Chairman*
Jesse Schulman, M.D.
Willis B. Mitchell, M.D.

Passaic—Irving Okin, M.D., *Chairman*
Joseph M. Keating, M.D.
Fred Vosburgh, M.D.
Frank Ash, M.D.
Norman Dingman, M.D.
John E. Leach, M.D.

Salem—John J. Reinhard, M.D., *Chairman*
Isadore Lipkin, M.D.
Charles E. Kilpatrick, M.D.

Somerset—George Greenberg, M.D., *Chairman*
Lewis C. Fritts, M.D.
John L. Spaldo, M.D.

Sussex—Martin I. Kirschner, M.D., *Chairman*
L. R. Eddy, M.D.

Union—H. S. Murphy, M.D., *Chairman*
C. H. Berry, M.D.
J. H. Gannon, M.D.
C. G. Kapp, M.D.
H. H. Zeitlin, M.D.

Warren—William Varney, M.D., *Chairman*
P. Q. Drake, M.D.
H. Bloom, M.D.

JAMES E. BRYAN, Administrator.

OBITUARIES

DR. EDWARD GUION

Dr. Edward Guion, Atlantic City's first health officer died at his home in Pleasantville on February 21, 1952.

Dr. Guion was born in Yonkers, N. Y., in 1873. He was graduated from the Medico-Chirurgical College in 1889. He remained in Philadelphia to complete his internship at the Samaritan Hospital and practiced there for another year. In 1902 he came to Atlantic City and became the first health officer, which post he held for 21 years. He was widely known for his work in the sanitation field and for 25 years was identified with supervision of county institutions. He was affiliated with many hospitals.

Dr. Guion had served as president of his county medical society and the Health Officers Association. He was a veteran of World War I and held membership in many fraternal organizations. For many years he was editor of his county medical society *Bulletin*.

DR. JULIUS HEILBRUNN

Dr. Julius Heilbrunn, Jersey City pediatrician, died on March 4, 1952, at the age of 60.

Dr. Heilbrunn received his medical education at Long Island Medical College and had been on the faculty of Columbia University School of Medicine for 20 years. He was one of the founders of Jersey City Hebrew Home for Aged and Orphans. His articles on pediatrics were published on an international scale in almost every known language.

Dr. Heilbrunn served in World War I. He was attending pediatrician at Christ Hospital and at Margaret Hague Maternity Hospital.

DR. JENNINGS S. LINCOLN

Dr. Jennings S. Lincoln, a Montclair physician since 1921, died on January 21, 1952, after a short illness.

Dr. Lincoln was born in Virginia in 1892, and was graduated from Johns Hopkins Medical School in 1918. After serving his internship at New York Hospital, he moved to Montclair. He was a past president of the medical staff at Mountainside Hospital and of the Associated Physicians of Montclair and Vicinity, and served in World War I.

DR. FRANK P. REALE

Dr. Frank P. Reale died at his home in Plainfield on February 7, 1952, at the age of 42.

Dr. Reale was graduated from Loyola School of Medicine, Chicago, in 1937. He served his internship at St. Peter's Hospital, New Brunswick and Muhlenberg Hospital, Plainfield. He was a member of the staff of Muhlenberg Hospital.

DR. HELEN F. UPHAM

Dr. Helen F. Upham, eye, ear, nose and throat specialist, died on February 3, 1952, at her home in Asbury Park.

Dr. Upham was born in 1877, the daughter of Asbury Park's first woman physician. She was graduated from Women's Medical College of Pennsylvania in 1903, where she interned. She served as assistant to Dr. Chevalier Jackson of Temple University Hospital when he was developing revolutionary technics for throat treatments and surgery. She spent two years in Vienna and Berlin where she further studied her specialty. She was for many years associated with the Monmouth Memorial Hospital, and was also on the staff of the New York Postgraduate Hospital. Dr. Upham was a prominent community leader and had served as president of many local and state organizations. She was a life member of the American Academy of Ophthalmology and Otolaryngology.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

A bill to carry out the legislative recommendations of the Tempory Committee on the Chronic Sick was introduced in the New Jersey Assembly as A-13, an administration measure, on March 10, 1952, by Assemblyman Elvin R. Simmill, of West Belmar, Monmouth County, and referred to the Judiciary Committee. The bill, as introduced, was essentially the same as that which was incorporated into the Committee's Report as recommended legislation.

The language of the bill states that it shall be known as "The Prevention of Chronic Illness Act"

It declares it to be public policy that responsibility for preventing, detecting, and caring for chronic illness must be shared by the state, counties, municipalities, health districts, voluntary agencies and institutions, and the public at large.

It provides for establishment within the State Department of Health of a Division of Chronic Illness Control. The director of the division shall be a physician qualified in public health who shall be appointed by the State Commissioner of Health. The division shall administer and foster programs to perform the functions provided by the legislation.

The bill further provides that the State Department of Health shall

1. Arrange for joint discussion of the problem of chronic illness by all agencies concerned to (a) formulate an adequate program and (b) to determine a formula for the ultimate division of the governmental share of the cost thereof.

2. Plan for provision of adequate visiting nurse and housekeeping aid services by appropriate public or private agencies.

3. Collect, prepare, and distribute information to inform both professions and public about chronic sickness.

4. Perform and encourage research.

5. Help strengthen child and adult health programs to prevent or retard the development of chronic illness.

6. Maintain and expand cooperative relationships with professional, public, and private agencies concerned with chronic illness.

The bill would establish within the Division of Chronic Illness Control an Advisory Council on the Chronic Sick to consist of nine members. Three *ex-officio* members shall be the Commissioners of Education, Health, and Institutions and Agencies. The Governor shall appoint six members who shall have special knowledge, experience, or interest in chronic illness. One shall be a physician appointed from a list recommended by The Medical Society of New Jersey. Their terms shall be three years and two terms will expire each year. Members of the Council will serve without compensation.

The Advisory Council shall appoint annually a Committee of Technical Advisers of professional, technical, and other persons. The number shall not exceed eleven. Their services may be called upon in developing policy and technical programs.

The Advisory Council will take an active part in shaping program and determining the size and purpose of the budget.

The bill provides that the State Department of Institutions and Agencies shall continue to be the sole state agency for rendering welfare assistance to the permanently and totally disabled and to needy persons in other categories of assistance.

If enacted, the bill will take effect immediately.

Members of the Temporary Committee on the Chronic Sick include the following: Johannes F. Pessel, M.D., *chairman;* Mrs. Asher Yaguda, *vice-chairman;* J. Harold Johnston, *secretary;* Miss Grace Anderson, R.N.; Miss E. Elizabeth Brown, R.N.; Mrs. Russell C. Caution; Mrs. Frank Fobert; Frederick P. Lee, M.D.; William H. Hahn, M.D., and Ellen C. Potter, M.D.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, February 8, 1952, at 9 p. m., DR. ANTHONY G. MERENDINO, presiding.

The guest speaker was DR. PRISCILLA WHITE, co-author with Jeslin of a text book on "Diabetes Mellitus"; world authority on Childhood Diabetes and Diabetes of Pregnancy. Her subject was "The Pre-and Postoperative Treatment of the Diabetic".

Dr. Holland announced that the Emergency Medical Service Plan was working smoothly with a high percentage of cooperation among participating members. He stated that advertisements of this service being rendered by the Medical Society would be placed in the newspaper and in the telephone directory.

Dr. Shavelson, reporting for the Cardiovascular committee, asked for the cooperation of the members in the current Heart Drive, either as volunteers or contributors, or both.

Dr. Sasseen, reporting on the Medical-Surgical Plan of New Jersey, announced that at a meeting to be held soon at Camden, plans and ideas for improvement of the present set-up would be discussed. He asked for suggestions from the members, and various problems were discussed; among them was whether the Plan should pay for medical attendance on surgical patients or for surgical procedures performed outside of hospitals. It was brought out in the discussion that generally the Plan was devised to care for major situations occurring in hospitals, that it seemed to be working well, and that no reason could be seen for suggesting any radical change. It was apparent, however, that there were many problems that needed further consideration, and Dr. Sasseen was instructed by the president to present these matters for possible solution.

Dr. Walter Stewart read to the Society a set of resolutions commemorating the passing of Dr. Norman Bassett. It was moved and seconded that the resolutions be adopted, that they be inscribed upon the minutes of our Society, and that a copy be forwarded to the bereaved family.

Dr. Merendino, with sincere regret, announced the passing of yet another beloved and respected colleague, Dr. Samuel Gorson. Dr. Levi Walker read to the members of the Society a set of resolutions that symbolized our sincere sorrow and sympathy. It was moved and seconded that the resolutions be adopted and that they be inscribed upon the minutes of our Society.

The following motion was made by Dr. Holland: "That Dr. Anthony G. Merendino be recommended by the Society to serve as State Examiner to the Compensation Court, a position recently vacated by the death of Dr. Samuel Gorson." The motion was seconded and unanimously carried.

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

A regular meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on February 14, 1952, at 9:00 p. m. President T. B. DICKSON, M.D., presided.

DR. TEMPLE FAY, professor of Neurosurgery at the Woman's Medical College, Philadelphia, was the guest speaker. Having recently returned from Europe where he aided in establishing Cerebral Palsy Clinics, his lecture aptly dealt with the "Medical Customs and Practice in Denmark with Particular Reference to the Rehabilitation of Crippled Children".

Dr. Ralph Van Meter read a resolution in memory of Dr. W. Edward Torrey, Jr., who died December 29, 1951.

ESSEX COUNTY

Elizabeth R. Brackett, M.D., Reporter

On March 13, 1952, the *Essex County Medical Society,* the Orange Mountain Medical Society and Clinical Society of the Oranges held a joint dinner meeting at the Hotel Suburban in East Orange.

DR. PAUL REZNIKOFF, professor of Clinical Medicine, Cornell University Medical College spoke on the subject of "Advances in Hematology". In discussing the anemias Dr. Reznikoff pointed out that a recent development of better laboratory methods for determination of the serum iron content and of the iron binding protein or factor provides the means for classifying many more anemias than formerly was possible.

The business meeting of the County Society was addressed by Mr. Sorg, President of the N. J. Blue Cross Plan on the proposed changes in the Medical-Surgical Plan Contract. The attending members approved resolutions that (a) maximum income limit to entitle subscriber to complete service benefits be construed to include the income of both husband and wife, (b) coverage with service benefits be offered without maximum income limits in group contracts, at 50 per cent increase in premium, with payment of 50 per cent or more to the physician or surgeon for services.

HUDSON COUNTY

John L. Varriano, M.D., Reporter

A regular meeting of *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center, February 5, 1952, with DR. WILLIAM J. GLEESON presiding.

The Committee for Postgraduate Medical Education, the Medical Defense Committee, the 1952 Annual Dinner Committee, and the Special Committee for Group Insurance submitted reports through their respective chairmen.

Dr. Ruoff, a member of the State Society's Medical Practice Committee, reported two matters referred to this Committee by the Executive Committee of the State Society. The first concerned the advisability of recommending to county societies that A.M.A. dues be included in county society billing rather than separately from the office of the State Society, as is now the case. A show of hands indicated an approximately equal number in favor of both systems of billing. The second matter pertained to the listing of doctors' specialties in the classified section of the telephone directory—which, although previously reviewed, has again come up for consideration. A show of hands indicated that a considerable number of members oppose the listing of special fields of practice in telephone directories. Attention was directed to the fact that Hudson County Medical Society has not sanctioned this practice in the past.

Elected to Active membership were: Dr. Morvyth McQueen-Williams of Englewood; Dr. Alfred J. Swyer of West New York; and Dr. Edward Sattenspiel of Jersey City.

Dr. Gleeson announced that a review of the emergency and night-call problem in Hudson County will be undertaken in the very near future.

As a guest at this meeting, Mr. Richard I. Nevin, Executive Officer of the State Society, addressed the meeting briefly. He commended this county society for its selection of Dr. Vincent P. Butler as a candidate for the vice-presidency of the State Society at its next Annual Meeting. Paying tribute to the late Dr. James F. Norton, he made fitting comment on the establishment of the James F. Norton Memorial Fund, announced publicly on this date.

The scientific session of this meeting—which marks the first of a series of joint activities on the part of our two organizations—was arranged in collaboration with the Heart Association of Hudson County. Through Dr. Nathan Frank, vice-president of the Heart Association and chairman of the program committee, it was possible to present as guest speaker, Dr. Janet S. Baldwin, assistant professor of Pediatrics, New York University Medical School, and chief of the Children's Cardiac Clinic, Lenox Hill Hospital. Dr. Baldwin presented a comprehensive illustrated lecture on "Newer Concepts in the Diagnosis and Management of Heart Disease in Infancy and Childhood".

MIDDLESEX COUNTY

George M. Benko, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on February 20, 1952, at 9:00 p. m., at the Roosevelt Hospital, Metuchen. Dr. Charles H. Calvin, the president, called the meeting to order.

The following were elected to Regular membership: Drs. John L. Kelly, New Brunswick on transfer from the Mercer County Medical Society; Robert W. Powers, New Brunswick, on transfer from the Essex County Medical Society; Paul Szafir, Carteret, on transfer from the Passaic County Medical Society. Dr. Gerald J. Aitken, Jr., Bound Brook, was elected to a two-year period of Associate membership.

Dr. Brett Ratner, professor of Clinical Pediatrics, New York Medical College, lectured on "Pediatric Allergy". Dr. Ratner correlated the nature of serum sickness with the allergic response and its various manifestations. His lecture vividly expounded the latest information on allergies in general.

Dr. Calvin then introduced Mr. Jacobs of the Medical-Surgical Plan of New Jersey, who explained all the features of the Plan. Mr. Jacobs also passed out folders describing the Plan and answered many questions on various details of its coverage. A postal-card survey will be made by the Society, in the near future, to learn the wishes of the members in regard to such coverage.

Dr. Calvin, reporting for the chairman of the Postgraduate Education committee, stated the attendance by members from Middlesex County itself was very poor at the postgraduate lectures and the committee felt that if sufficient interest was not forthcoming it would be better to cancel the proposed postgraduate lectures intended to begin in November.

A communication from the State asks that a list be made of the members who are willing to make examinations on people who the State feels are out of work too long for the illness indicated on their disability compensation forms. All those wishing to perform such examinations are requested to notify Dr. William C. Wilentz.

MONMOUTH COUNTY

Sidney M. Hodas, M.D., Reporter

A regular meeting of the *Monmouth County Medical Society* was held on January 23, 1952, at the Pleasant Inn in Red Bank, with Dr. J. Berkeley Gordon, President, in the chair. The feature of the evening was a presentation by Dr. David Schwimmer, instructor of Medicine, New York Medical College, Flower and Fifth Avenue Hospital, New York City, on "Nutritional Factors in Medicine".

A report was made on the December dinner-dance, which was jointly sponsored by the Society and the Woman's Auxiliary, and was held at the Spring Lake Golf and Country Club.

The Executive Committee reported a meeting with County Prosecutor J. Victor Carton, in which narcotic addiction problems were discussed. It was announced that a mimeographed digest of the relevant legislation was being prepared to be sent to each member.

Dr. Samuel Edelson made the report of the Nominating Committee for the elections to be held at the next meeting.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Medical

Society Building, Paterson, on February 19, 1952, at 9:00 p. m. SANDOR A. LEVINSOHN, M.D., President, presided. Dr. Levinsohn welcomed the members to the first regular meeting in the Society's own building and paid tribute to Dr. Frank W. Ash who has been Chairman of the Building Trustees and whose efforts were mainly responsible for the beauty and utility of the Society's own home. Dr. Levinsohn then stated that it was hoped really to utilize the building to the fullest extent possible by holding postgraduate classes and lectures as are done in Newark and New York, and eventually to establishing a library.

JOSEPH I. ECHIKSON, M.D., chairman of the Executive Committee, N. J. Division, American Cancer Society, spoke briefly on the subject of treatment of cancer by radioactive isotopes and their availability. Dr. Echikson then introduced the speaker of the evening, CHARLES S. CAMERON, M.D., F.A.C.S., Medical and Scientific Director of the American Cancer Society; Special Consultant Cancer Control Grants Section, National Cancer Institute, U. S. Public Health Service; Attending Surgeon, Memorial Cancer Center, who gave a very interesting talk on "Frontiers in Cancer Control". The discourse was effectively illustrated by lantern slides, and was very well received.

UNION COUNTY

Leslie M. Townsend, M.D., Reporter

As a pleasant innovation the February meeting of the *Union County Medical Society* was a joint assembly of physicians and their wives. Arrangements for this first joint meeting, which was held at the Johnson and Johnson auditorium in Cranford on the eve of February 14, were made by the *Woman's Auxiliary* with MRS. EDWARD O. MACDONALD of Roselle Park as chairman for this meeting. Speakers were introduced by Mrs. Austin J. Tidaback of Union and Mrs. Robert O. Yuckman of Elizabeth, who are president and president-elect respectively of the Auxiliary for the current year.

The first speaker was DR. HARROLD A. MURRAY of Newark, president-elect of The Medical Society of New Jersey, who spoke on *Medicine and Public Relations*. Dr. Murray cited the many activities promoting better medical public relations from national down to county society levels but emphasized that, in the last analysis, the public relations job was an individual one for each doctor, the doctor's wife, the nurse or office aide, and every patient contact. Dr. Murray urged that we aim, not only to have satisfied and happy patients, but to give the added measure of service and show the personal interest in the patient as an individual. That alone would recapture for us more of the affection enjoyed by doctors of previous generations.

The second speaker of the evening was MR. FREDUS A. WHITE, a reporter and correspondent for the Newark Evening News at the United Nations organization since the establishment of U. N. Mr. White gave much background information on the U. N. and emphasized the many positive accomplishments of the organization.

All present agreed that this first joint meeting was highly successful. The Woman's Auxiliary is to be congratulated on the choice of program. Before adjournment many expressed the hope that more such combined meetings may be held in the future.

PROSTHETISTS AND ORTHOTISTS SERVICE

A clearinghouse service on competent, ethical technicians specializing in braces, limbs, plastic eyes, or facial and body prosthesis is being established. Qualified dentists doing obturator work or plastic eyes are included. Information will be available to *all* members of the medical profession on request, directed to the Academy-International of Medicine and Dentistry, 214 West Sixth Street, Topeka, Kansas.

MUSCULAR DYSTROPHY APPEAL

Announcement has been made of grants recently awarded by the Muscular Dystrophy Association of American to Duke University for the study of muscle metabolism; to Alabama Polytechnic Institute for study of the relationship between diet and dystrophy; and to the University of Iowa for the further study of muscle metabolism. The Association is also sponsoring six of the research programs in various parts of the country.

Contributions to this worthy cause may be sent to the Muscular Dystrophy Association, 21 East 40 Street, New York 16, N. Y.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Thomas H. McGlade, Haddonfield

Twenty-five Years of Service is to be celebrated at our annual state meeting. The place is Haddon Hall, Atlantic City. The important dates are May 19, 20 and 21. All Auxiliary members and all wives of physicians, who are not members, are urged to attend and participate in this special celebration.

We shall review, in retrospect, the achievements of the Auxiliary during the past twenty-five years. We shall learn of the plans which have been formulated for the future.

Arrange now to take this opportunity to meet old friends and make new ones, thus furthering the friendliness among physicians' families. A special event of which we are happy to inform you is the reorganization of the Woman's Auxiliary to the Cumberland County Medical Society. Cumberland County was reorganized at a luncheon meeting, in the Cumberland Hotel, Bridgeton, on March 17. We congratulate these new members and are proud to have them share with us the privilege of belonging to the Auxiliary.

EXECUTIVE BOARD MEETINGS

Mrs. Stuart Zeh Hawkes, Chairman, Press and Publicity

The Board Meeting of The Woman's Auxiliary to The Medical Society of New Jersey was held on Monday, January 14, 1952, at the Executive Offices of the Medical Society in Trenton, with Mrs. Thomas McGlade presiding. A pleasant coffee hour was held before the meeting for the early arrivals. Following reports of the officers, committee chairmen and county presidents, the meeting adjourned for luncheon at the Carteret Club, and reconvened after luncheon. Mrs. R. John Cottone, chairman of the Nominating Committee, presented the following report: *President*—Mrs. Edward Dyer; *President-Elect*—Mrs. Frank Forte; *First Vice-President* — Mrs. Paul Rauschenbach; *Second Vice-President*—Mrs. Andrew Ruoff; *Treasurer*—Mrs. Asher Yaguda; *Recording Secretary*—Mrs. Bertram Sauerbrun; *Directors* — Mrs. Ralph Buchanan, Mrs. Lloyd Hamilton. Nominations were made from the floor for delegates and alternates to the Annual Convention of the Woman's Auxiliary to the American Medical Association. Mrs. Harry Subin, Convention chairman read an invitation to Auxiliary members to the General Session of the New Jersey Medical Society at their Annual Convention.

A Quiz Session followed the meeting, conducted by Mrs. Frank Forte, First Vice-President, A discussion was held concerning the various problems of the county auxiliaries and featured questions submitted by the county presidents-elect. The members of the panel were Mrs. R. John Cottone, Mrs. William Dodd, Mrs. Don A. Epler, Mrs. William Gleeson, Mrs. Lodovico Mancusi-Ungaro, Mrs. Robert Walker and Mrs. Frederick Wandall.

Mrs. Thomas McGlade presided at the Executive Board meeting held at the State Society Headquarters on Monday, March 10, 1952. Following the coffee get-together the meeting convened. The officers, chairmen and county presidents submitted reports. It was announced that the Spring Public Relations Conference will be held on Wednesday, April 30, at 10:00 a. m. at the State Society Headquarters, Trenton. Mrs. Stewart F. Alexander, Public Relations Committee chairman, will preside over the program which will discuss the need of a medical-dental school in New Jersey.

Luncheon was enjoyed by the Board at The Carteret Club following the meeting. The Program chairman, Mrs. Frank Forte, introduced the after-luncheon speaker, Mr. James Bryan, Administrator of the Medical-Surgical Plan of New Jersey. Mr. Bryan discussed the Medical-Surgical Plan, which is New Jersey's Blue Shield Plan, and what it means to the doctor and to the patient. This is the tenth anniversary of the Plan.

AUXILIARY REPORTS

Atlantic County

Mrs. Harry P. Goodman
Chairman, Press and Publicity

Over 250 women, representing 40 various organizations in Atlantic County met at the Strand Hotel on February 19, 1952, for the annual Community Day Tea. This affair is sponsored by the *Woman's Auxiliary to the Atlantic County Medical Society* and the Woman's Club of Atlantic City, for the purpose of bettering public relations between the medical society and lay organizations.

Mrs. Jardine, president of the Woman's Club, Mrs. Matthew Molitch, president of the Auxiliary, and Mrs. Herbert Axilrod, first vice-president of the Auxiliary and chairman for the afternoon, extended greetings.

Mrs. Hugh Kearney, chairman of Community Health, stated that there are nine programs offered free to all organizations. It was also stated that the Auxiliary would furnish any organization with speakers on "Safety".

The speaker of the afternoon was Mr. Richard I. Nevin, Executive Officer of the State Medical Society. His topic was "Medical Practice—A Changing Picture".

Bergen County

Mrs. W. Johnson,
Chairman of Press and Publicity

A regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held on February 12, 1952, in the Lounge of the Nurses' Home at Englewood Hospital. Mrs. Thomas Garrett, conducted the business meeting at which the reports of officers and chairmen of committees were presented. A proposal for the establishment of nurses scholarships was most enthusiastically received by the large group in attendance, and this program will be presented at the March 11 meeting for a final consideration and voting. Spurred by the incentive of seeing our philanthropic fund performing such valued service as aiding worthy students in the pursuit of nursing training, the plans for the April Fashion Show and Bridge are full of promise for a most successful and charming affair. Mrs. Thomas DeCecio of Cliffside is in charge of this event, which is to be held at the Woman's Club, in Hackensack.

A Valentine tea followed the business meeting. Mrs. William Palazzo was in charge of refreshments.

Essex County

Mrs. Louis L. Covino,
Chairman, Press and Publicity

The February meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held at the Contemporary Auditorium, Newark, on February 25, 1952, Mrs. John Torppey presiding. Immediately following the meeting, our Arts and Hobbies Day chairman, Mrs. Philip D'Ambola, presented a delightful program to about one hundred members and friends.

A one-act play, "The Groom's Bouquet", starring Mrs. Matthew Iatesta as the beautiful young bride-to-be, with "last minute" "before-the-ceremony" hysterics and Mrs. Don A. Epler as her understanding mother, received much applause. In the supporting roles of her future mother-in-law was Mrs. John O'Sullivan, the impish younger sister, Mrs. D. Stevens, the sophisticated out-of-town cousin with a "crush on the groom", Mrs. W. Hyland and the two lovely bridesmaids, Mrs. A. B. Iannone and Mrs. George Parrell. Mrs. A. B. Iannone also directed the play.

Next on the program was Mrs. Harold Grubin who gave two beautiful vocal selections, followed by Mrs. Ralph Autorino who did a pantomime on Little Red Riding Hood, that had the audience hysterical with laughter. Mrs. Arthur Ruccia sang and the chorus danced to "Waiting at the Gate for Katie". Mrs. William Minningham, Jr., also sang one of the old tunes "Let's Do It Again". In costume of the "Roaring Twenties", Mrs. John Insabella and Mrs. Anthony Gianotta, with their male partners (slacks and blazer jackets made you think so) Mrs. Anthony Biunno and Mrs. Frank Belucci danced the Charleston. Also in the dance chorus line along with Mrs. A. Biunno was Mrs. Jesse Glazier, Mrs. Max Block, Mrs. Thomas Cantalupo, Mrs. A. B. Iannone, Mrs. Robert Anderson, Mrs. Frank Belucci and Mrs. William Di Giacomo.

Another highlight of the Variety Program was an unusual dance performed by the Caprio sisters, Mrs. Thomas (Genevieve) Messino and Mrs. Joseph (Livia) Di Norcia. Delightful, indeed.

Closing the show with a solo tap dance was Mrs. Philip D'Ambola who did a superb job of putting the program together. Helping with this great task as co-chairmen were Mrs. A. B. Iannone and Mrs. Arthur Ruccia.

Also, as part of the Arts and Hobbies Day, a baking contest was sponsored and many membe brought in their specialties with the hope of winning a prize. Mrs. Lucien della Ferra was chairman of the contest. After Mrs. Albert Tucker, Mrs George Maggio and Mrs. George Parrell had walked off with the prizes for the best entries, their exquisite samples of the culinary art were served to the guests following the program. Tea was poure by our president, Mrs. John Torppey, and our president-elect, Mrs. Pascal Baiocchi.

Indeed, it was a tremendous success.

Hudson County

Mrs. Sidney Chayes, Chairman of Publicity

Mrs. Albert Lepis and Mrs. Fred Sachs were co-chairmen of a successful Dessert Bridge held February 19, 1952, at the Jersey City Masonic Club, sponsored by the *Auxiliary to the Hudson County Medical Society* for the Nurse Scholarship Fund. Two students are in training as a result of the project and Mrs. Samuel Scott, chairman of Nurse Scholarship Committee, announced that two additional scholarships will be offered.

The Auxiliary held its annual Open Health Meet-

ing March 3, at Murdoch Hall. In the absence of Mrs. Morris Bresev, President of the Auxiliary, Mrs. Fred Sachs presided, welcomed those present and introduced Mrs. Marshall Bergen, chairman of Public Relations, who presented Dr. William J. Gleeson, President of Hudson County Medical Society. He expressed his gratitude to the Auxiliary for their assistance during the past years and introduced the guest speaker Elmer L. Sevringhaus, M.D., Director of Clinical Research, Hoffmann-LaRoche, Inc., Director of Endocrinology and Metabolism, Medical Center, Jersey City and Physician-In-Charge of Nutrition Clinic, Amsterdam Housing Unit, New York City. His topic was "The Essentials of Diet for Maintaining Health". Due to a previous commitment, Dr. Sevringhaus was unable to remain for the question and answer period and Dr. Gleeson very graciously took his place.

Greetings were brought from the State Auxiliary by its president, Mrs. Thomas H. McGlade and she congratulated the members for their part in the program of the organization.

At the conclusion of the program a social period was enjoyed and refreshments were served by the hostesses, Mrs. Joseph Giannasio and Mrs. Michael Cerchio, assisted by a very capable committee.

BOOK REVIEWS

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of Northern New Jersey

Technical Methods for the Technician. By Anson Lee Brown, M.D. Ed. 4. Pp. 784. Columbus, Ohio, Anson L. Brown, Inc., 1951. ($10.00)

Many books have been published for the clinical laboratory worker but the presentation of the material in most cases has not been sufficiently descriptive. This book reduces considerably the need for outside reference, a boon to the busy technician.

One of the unusual features of the book is the abundance of pictures with key figures which are very descriptive. Here is a fine example of the adage "a picture is worth a thousand words". Nothing is taken for granted in the presentation which increases the work's appeal for the beginning worker in the field. At the end of each chapter there appears a series of questions which provides an excellent means of reviewing the content of the chapter. At the end of the book a list of reference books and journals useful to the clinical laboratory is appended. The list is excellent and any laboratory possessing such a diversified library is a rich one.

The main objection this reviewer raises is the author's reference in the description of a test to the use of a specific (brand name) colorimeter. This may be confusing to the beginner not owning or using such an instrument. The experienced technician knows that, in most instances, with proper calibrations and standardization he can apply any method to nearby standard colorimeters. There are some typographic errors, several of which already show hand correction and some which need correction. The user should be on guard for these. The technical qualities of publishing are fair and so is the price considering that the book has been privately published by the author. The text is highly recommended and should find a place in all collections on laboratory methods and diagnosis.

Jay Burger, M.S.

Brain Metabolism and Cerebral Disorders. By Harold E. Himwich, M.D. Baltimore, Williams and Wilkins Company, 1951.

This complete and up to date treatise is supplemented by an enormous bibliography of 1042 references and by many charts and graphs, which clarify the text. Since carbohydrates constitute the sole foodstuff of the brain it is good that so much space is assigned to carbohydrate metabolism and to mechanisms of hypoglycemia. A whole chapter is devoted to mechanisms of narcosis including the effects of barbiturates, nitrous oxide, alcohol, ether, and cyclopropane on brain metabolism. The author demonstrates that anoxia, hypoglycemia and narcosis depress the metabolism of the brain. The higher phyletic levels have a higher metabolic rate and are the first depressed, thus liberating from their control the lower levels. The stages of hypoglycemia, anoxia or narcosis are to a great extent due to this dissolution of the nervous system according to the concept of John Hughling Jackson. The book should be "must" reading for anesthesiologists and neuropsychiatrists, especially for those who do insulin coma therapy.

Eugene Revitch, M.D.

Physical Medicine and Rehabilitation for the Clinician. Edited by Frank H. Krusen, M.D. Pp. 371. Philadelphia, W. B. Saunders Company, 1951. ($6.50)

This unique book presents information prepared by a group of authoritative writers in the fast-growing and progressive field of physical medicine and rehabilitation. Twenty-four contributors from leading hospitals and medical centers have brought physical medicine and rehabilitation up-to-date from the standpoint of therapy, diagnosis, clinical aspects, and the fundamentals of anatomy, exercise and physiology.

The latest developments in this field, which are of particular interest to the specialist in physical medicine, or physiatrist, are discussed. In addition, the general practitioner, the medical student, the

physical therapist, and the occupational therapist will find the clinical aspects of the field thoroughly covered.

Of special interest to the clinician, is an important chapter on prescription writing in physical medicine. Too often, only a vague prescription is written or the choice of recommended treatment is left entirely to the therapist. Sample prescriptions illustrate "how to do it" in prescribing physical therapy.

One of the notable advances in medical action during the past two decades has concerned the disorders of organic function and the application of physical procedures to restore and maintain a normal or nearly normal physiologic state. The information covered in this book will give a better consideration of this problem.

JOHN J. DEDINSKY, M.D.

Spatial Vector Electrocardiography. By Robert P. Grant, M.D., and E. Harvey Estes, Jr., M.D. Pp. 149. Philadelphia, The Blakiston Co., 1951. ($4.50)

Although the rapidly accumulating mass of literature on the vector approach to electrocardiography has already outdated this small volume, the book serves the important function of lifting the veil of obscurity which so often camouflages a new subject. The method of spatial vector analysis differs from conventional electrocardiography only in that it establishes another "point of view", but there are new concepts and new terms with which the experienced cardiologist must become familiar. Papers in medical journals, dealing at length with minutiae of a subject, assume so frequently a basic knowledge which, in spatial vector analysis, was not readily available to physicians not working in that field. This primer bridges the gap by presenting a fundamentally simple subject in uncomplicated manner, furnishing the A B C's of what appears to be an important step forward from the empiricism of conventional "pattern" electrocardiography.

The spatial vector method involves recognition of electrical forces as vectors projected in three dimensions, the mean vector at any given moment establishing the magnitude and direction of a curve which connects all instantaneous vectors. The loops which result, representing QRS or T activity, are the vectorcardiograms. Inspection of such tracings provides a basis for clinical interpretation in which position of the heart and pathologic imbalance of electrical forces are correlated so that deviations due to either factor are readily recognizable. The onus of memorizing "patterns" is thus obviated, and the observer need apply only simple electrical and geometrical principles to achieve a reasonably accurate interpretation of cardiac phenomena.

The book (and the subject it introduces) are highly recommended to the physician who finds himself dissatisfied with the numerous blank areas of conventional electrocardiography, and for whom the ideal interpretation is based on recognition of physiologic processes rather than memorization of "facts". An investment of several hours with pencil, paper, and a copy of *Spatial Vector Electrocardiography* provides the basis for an appreciation of principles which most certainly underlie future advances in cardiographic technic and analysis.

SANFORD M. LEWIS, M.D.

Untoward Reactions of Cortisone and ACTH. By V. J. Derbes, M.D., and T. E. Weiss, M.D. Pp. 77. Springfield, Ill., Charles C. Thomas, 1951. ($2.25)

Acute perforation of duodenal ulcers, pathologic fractures in osteoporotic patients, and the development of frank psychoses are among the more dramatic complications of ACTH and cortisone therapy that have been reported. Certain infections, e.g., poliomyelitis and tuberculosis, are made worse, and criteria for the diagnosis and evaluation of other infections may be impaired in patients receiving these agents. The retention of sodium and water may precipitate congestive failure in cardiacs who are treated with ACTH and cortisone. These and other undesirable side effects of such therapy are described in this small compact volume, number 131 in the American Lecture Series. Drs. Derbes and Weiss, have carefully reviewed the literature for reports of such reactions and collected them here, following a chapter devoted to summarizing the physiology of the pituitary-adrenal axis.

In addition to the complications mentioned, the effects of ACTH and cortisone on the glands of internal secretion, electrolytes, the heart and blood vessels, skin, central nervous system and gastrointestinal tract are described. Each chapter is headed by an outline of the abnormal reactions, followed by more extensive discussion of the individual topics.

For physicians using these drugs, this little book presents succinctly the untoward effects that may occur, and stands as a warning against their indiscriminate use.

ROWLAND D. GOODMAN, 2nd, M.D.

Diabetes Control. By Edward L. Bortz, M.D. Pp. 264. Philadelphia, Lea & Febiger, 1951. ($3.50)

In no condition is knowledge of a disease so important to the patient as in diabetes. This excellent treatise is a valuable guide not only for the patient but even for the busy practitioner. The style is simple and clear and the book is concise, practical and up-to-date in its approach. The author's wide experience is detailed in a well-organized manner and serves admirably to acquain. the diabetic patient with his disease.

The reviewer, however, feels that Dr. Bortz pays too detailed attention to the minutiae of diets. Only the exceptional patient will pay heed to all his recommendations. The results are the best if the diet is a normal one and, when prescribed, individual meals are not altered, postponed, "switched" or omitted. This is particularly true when insulin is necessary. Throughout the book optimism and hope form the keynote. Nothing is better for the esprit d' corps of the impressively increasing number of newly discovered diabetics. In simple language, Dr. Bortz tells what diabetes is, what causes

it, how it is controlled and what symptoms patients must watch for and guard against. He outlines the important precautions necessary to prevent complications. His explanation of acidosis (coma) and its prevention is unsurpassed. The important psychologic aspects are not neglected. He gives proper emphasis and attention to the various insulins currently in use.

A special and invaluable feature is a section containing 75 questions and answers on subjects pertinent to diabetic control. Superfluous detail and needless elaboration are here absent, although no important phase or subjects are omitted. The book is highly recommended for both the patient and general practitioner because such a large amount of valuable and timely information has been condensed into a relatively small volume with excellent discrimination.

BENJAMIN SASLOW, M.D.

Medical Terminology Made Easy. By J. Harned, R.R.L. Chicago 1952. Physicians Record Company. Pp. 275. ($5.00)

By now, more laymen than physicians are concerned with the distribution of medical care. The list includes dietitians, social workers, psychologists, medical secretaries, technicians, nurses, physical therapists, hospital administrators, and several other peripheral categories. Since medicine has developed a precise but—to the layman—bewildering jargon, there is real need for a guide book through the verbal jungle. This, Miss Harned offers. Since most of the persons for whom the book is intended are in the underpaid classification, it is too bad that this slim volume costs five dollars. The text teaches the elements, meanings and etymologies of medical words. It teaches in a somewhat school-marmish fashion. For example, on page 27 is a set of instructions about learning-by-rote and homework assignments which is out of place in adult education.

Dr. Davison is listed casually within a paragraph as: Wilbert C. Davison, A.B., B.A., B.Sc., M.A., M.D., D.Sc., L.L.D. In addition to being embarrassing to Dr. Davison this is poor teaching for medical secretaries. They have to learn that a doctor of medicine simply does not, in the middle of a paragraph, use a string of initials like that after his name. Another source of confusion is Miss Harned's novel spelling: "Mucus membrane" (page 151). Most of us prefer the more conventional "mucous membrane". Since medical secretaries may look on this book as an authoritative one, such heterodoxies should have been avoided.

One might also question her list of "legitimate and approved abbreviations". Thus, the only "legitimate and approved" meaning for "C.V." is—guess what? No, not cardiovascular; C.V. means "tomorrow evening". Not in my Steadman nor in Gould, but that's what Miss Harned says. *Aeg.* is the "legitimate and approved" abbreviation for "patient". I always thought that "h.d." (my favorite initials) meant "hearing distance" but Miss Harned says that the only legitimate and approved meaning is "at bedtime". Another new one—new to me anyway, is S.S.V. which is the approved abbreviation for "under a poison label" and "k.k." which means "knee kicks".

Some other odds and ends of misinformation include: "diathermy means heating cells almost to point of destruction" (page 50) and a psychopath is one "ill in the mind" (page 66). Since Miss Harned is an R.N. as well as an R.R.L. she ought to know better than to tell the world that "the Babinski indicates a disease of the spinal cord" (page 133). Medical secretaries, if they ever type articles for publication, must learn to capitalize trade-named drugs or otherwise indicate who owns the registration. I hope Parke-Davis doesn't find out that Miss Harned spells "Adrenalin" with a small "a" (page 110), and fails to credit the trade-name owner. And as a sample sentence, I am left speechless by "because of a tumor of the larynx, the patient has a constant aphasia" (page 130). Don't say anything now, but what the patient has is an anarthria. Unless I have lost my own memory for symbols, aphasia means a loss of memory for symbols.

However, nothing is perfect, and perhaps one should not be too critical of these numerous errors. Still, in a book which ought to teach meticulousness, these flaws are distressing. And since the volume may become a guide for medical neophytes, the errors can do a certain amount of harm.

On the positive side, it may be said that the book displays something of the drama and color of medical etymology and gives a sound body of basic information about the structure of medical terminology. I hope Miss Harned will rewrite it, delete the errors, and have the publishers issue it in a paper-bound edition at a lower price. Properly re-edited, it might well become the standard work on its subject. As is written on page 201, the lay equivalent of "amenorrhea" is "ain't seen nothing yet".

HENRY A. DAVIDSON, M.D.

Rehabilitation Nursing. By Alice B. Morrissey, B.S. New York, G. P. Putnam's Sons. Pp. 229. 1952. ($5.00)

The author has organized her material ably and her style of writing is marked by the use of careful explanation and apt illustration. Basically the technics of good nursing care and the treating of the total personality are emphasized.

Of importance and valuable aid to the nursing profession are the chapters on the integration of personality in disability and prevention of physical deformities. These principles may be applied, not only to the disabled person, but to anyone ill at home or in a general hospital.

The author, a supervisor and instructor of rehabilitation at Bellevue Hospital Rehabilitation Center, is well qualified to write this book which will be used by the nursing profession, not only in rehabilitation, but which will very likely be included in the curriculum of all schools of nursing.

GRACE J. MONTAGRIFF, R.N., B.S.

Volume 49
Number 4

TUBERCULOSIS

ABSTRACTS

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV April, 1952 No. 4

AN OUTBREAK OF RESPIRATORY TUBERCULOSIS IN A SCHOOL

By R. T. Bevan, M.D., P. T. Bray, M.D., and J. F. Hanly, M.D., British Medical Journal, October 6, 1951.

Tuberculosis is frequently cited as an example of a disease which could be combated more effectively if a closer liaison existed between the hospital, general practitioner, and preventive medicine services. The localized outbreak to be described is therefore not only of clinical but also of medical administrative interest.

The first intimation of this outbreak followed an observation by the pediatrician who was investigating three cases of clinical primary respiratory tuberculosis in a hospital and had made domiciliary visits to two similarly affected children. Noting that they all came from the same area, he informed the County Medical Officer on July 15, 1950. It was quickly confirmed that all the affected children attended the same school, and the school became the center of investigations. Inquiries revealed that a member of the teaching staff had been absent from May 23 to June 26 suffering from laryngitis, but on July 17, when the school was visited by the Deputy County Medical Officer, this teacher was again absent, this time with "haemoptysis," which had occurred on the previous Friday. In due course the diagnosis of respiratory tuberculosis was confirmed. There was no common supply of milk at the homes of the affected children. The school milk supply was pasteurized.

Future action was decided at a meeting of the pediatrician, the local chest physician, and the County Medical Officers. A letter sent to all parents asked their consent to carry out Mantoux skin tests on the children at the school. All children who were absent from school were investigated. Of the 186 children in the school 176 were tested immediately. This excellent cooperation of the parents reflects their keen interest in the welfare of their children. Those found to be Mantoux-positive were X-rayed. The results of the tests and examinations are shown in Table 1. Mantoux testing consisted of the intradermal injection of 0.1 ml. 1/10,000 old tuberculin followed by 0.1 ml. 1/100 in the negatives.

TABLE 1

RESULTS OF MANTOUX AND X-RAY TESTS AT BEGINNING OF INVESTIGATION, CLASSIFIED BY SCHOOL GRADE: JULY, 1950

Class	*Age range*	*Number tested*	*Mantoux reactors*		*Number showing X-ray evidence of tuberculosis*
			Number	*Per cent of total*	
Total ..		176	52	30	8
Infants	5-7	48	13	27	4
Classes I and II	6-9	31	8	26	1
Class III ...	8-11	26	12	46	2
Class IV	9-12	33	8	24	1
Forms I and II (Secondary)	11-14	38	11	29	

The schoolteacher who was now the suspected source of infection was in charge of Class III. Why, then, should the infants' class show the greatest incidence of cases with X-ray evidence of tuberculosis? The explanation was apparent when it was discovered that this teacher was in charge of the infants' class from May 8 to 12 owing to the temporary absence of the infants' class teacher.

The return to teaching duties following the initial period of sickness was unfortunate, since it was probable that further children were infected during this period. It was essential, therefore, to repeat the routine tests when the children returned to school after their summer vacation, as by that time the Mantoux test would have had time to show conversion. The local general practitioners were kept fully informed of the position, so that when children presented suspicious symptoms they were referred immediately to the local chest clinic. During the school vacation additional cases were brought to light in this manner.

One of the difficulties was to avoid undue alarm, and the parents were given an opportunity to be present at a meeting in the school. This diminished the natural anxiety and was a means of health education of the general public.

In November all those children who were Mantoux-negative in July or who had not been previously tested were asked to submit to investigation. With few exceptions the parents were prepared to cooperate. The results obtained are shown in Table 2 which emphasizes the abnormal picture of Class III—the class whose teacher had developed pulmonary tuberculosis.

In all twelve children who showed evidence of clinical tuberculosis the treatment consisted only of rest in bed, at home or in hospital, with clinical and radiological supervision. Streptomycin was not given.

All the teaching and non-teaching staff of the school immediately volunteered to undergo X-ray examinations, and, apart from the affected teacher, none showed evidence of active tuberculosis.

This local outbreak is an example of the danger that a teacher suffering from pulmonary tuberculosis can be to school children. The favorable outcome does not detract from the need for periodic compulsory X-ray examinations. Pulmonary tuberculosis, however, may be rapidly progressive in a young adult and annual examinations may not be a sufficient safeguard. Six-monthly routine examinations may be necessary to prevent outbreaks such as the one described.

Table 2
Results of Mantoux and X-ray tests at completion of investigation, classified by school grade: November, 1950

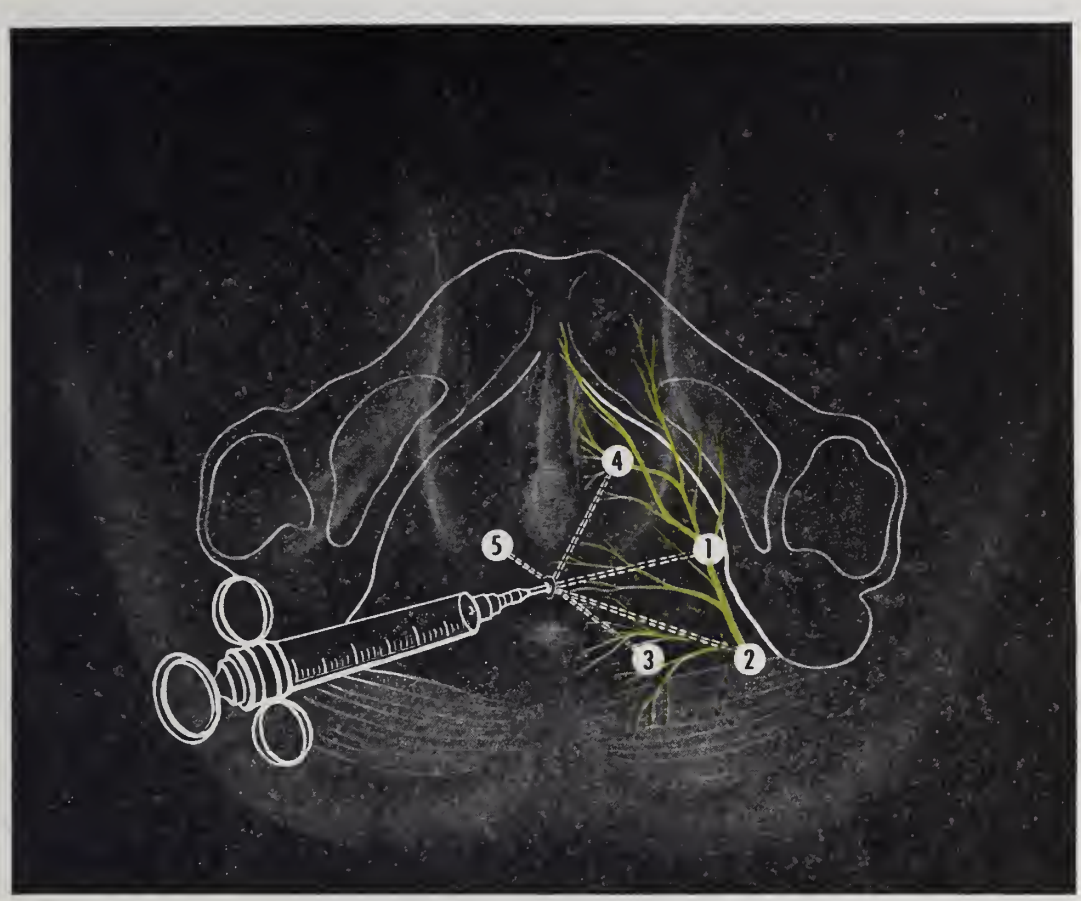
Class	Number tested	Mantoux reactors		Number showing X-ray evidence of tuberculosis
		Number	Per cent of total	
Total	184	69	38	12
Infants	49	15	31	4
Classes I and II	33	12	36	1
Class III	28	21	75	6
Class IV	34	8	24	1
Forms I and II (Secondary)	40	13	33	.

The histories suggest an incubation period between the limits of 40 and 62 days.

Summary

Five cases of clinical primary respiratory tuberculosis were reported in pupils of the same school. The probable source of infection was traced to a schoolteacher. Immediate Mantoux and X-ray testing revealed three further cases. The return of the teacher concerned to school after a short period of absence necessitated a follow-up examination of the pupils, and four further cases were brought to light. The classes predominantly affected were those with which the teacher had come into closest contact.

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[1]Heins, H. C.: Pudendal Block with Hyaluronidase, J. South Carolina M. A. *46*:309 (Oct.) 1950.

[2]Baum, F. E.: The Use of Hyaluronidase in Pudendal Block, Am. J. Obst. & Gynec. *60*:1356 (Dec.) 1950.

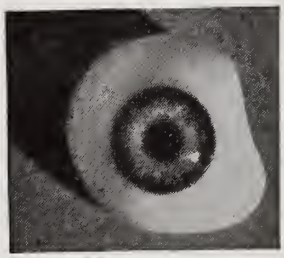
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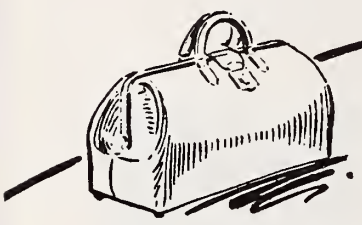
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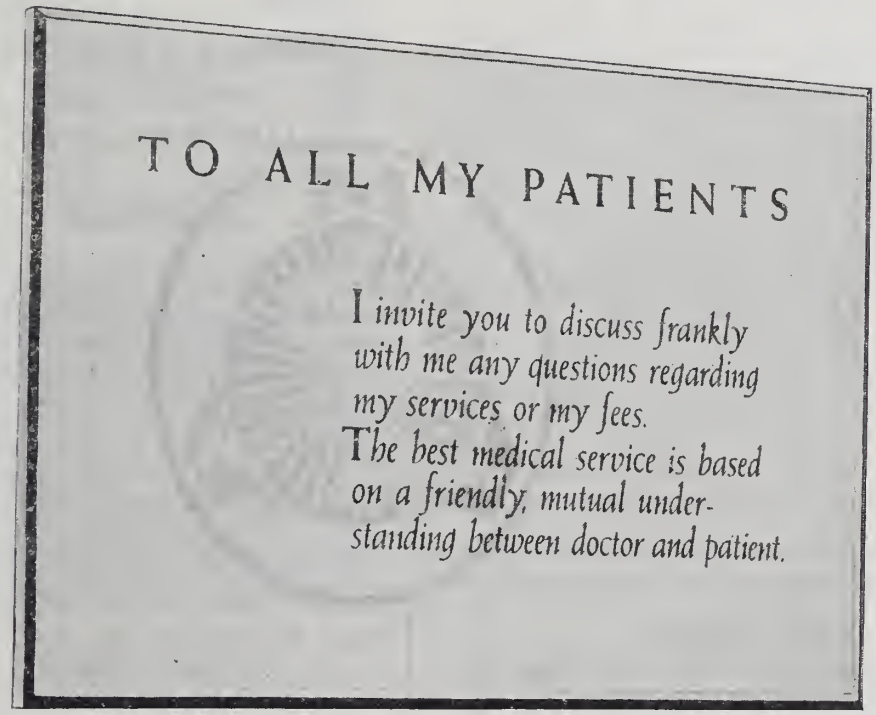
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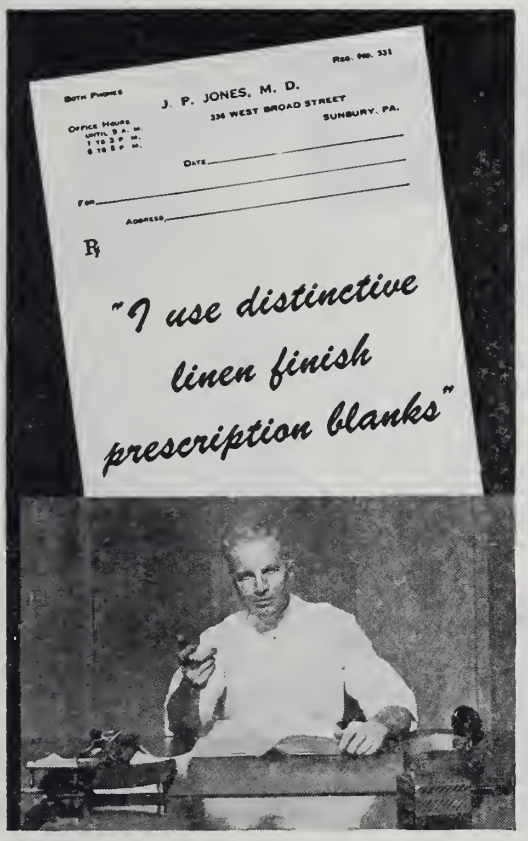
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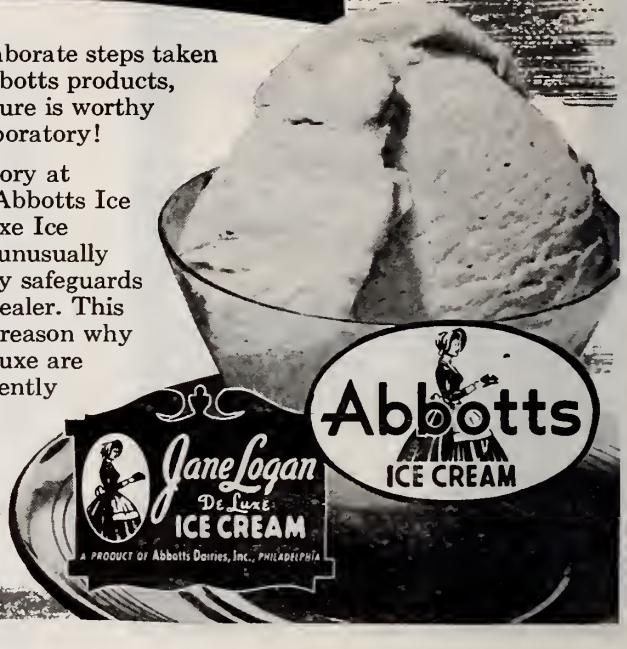
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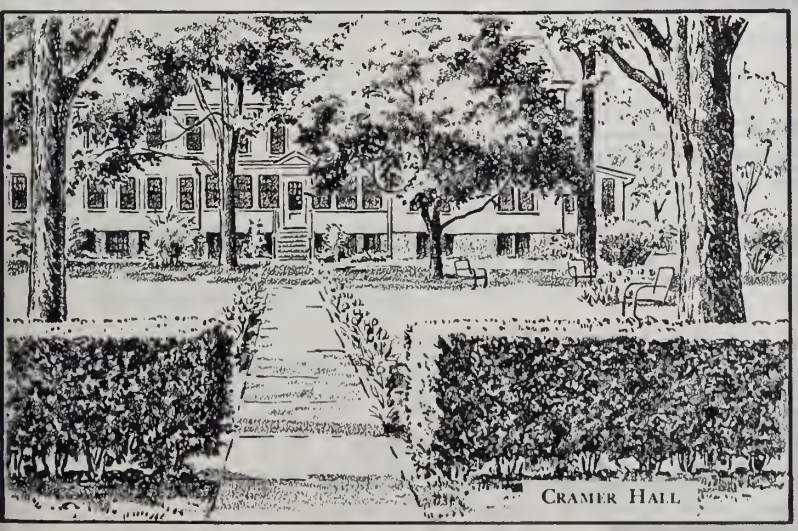
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Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

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GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull 54: 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

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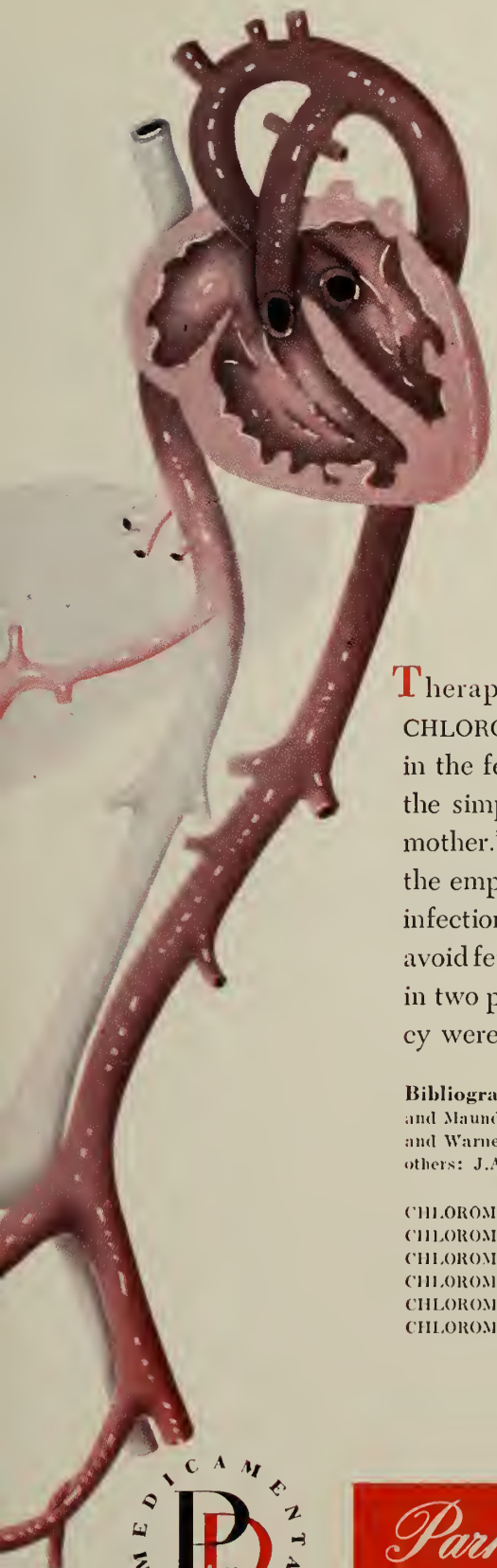
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Bibliography: (1) Stevenson, C. S.; Glazko, A. J.; Gillespie, E. C., and Maunder, J. B.: J.A.M.A. *146*:1190 (July 28) 1951. (2) Scott, W. C., and Warner, R. F.: J.A.M.A. *142*:1331 (April 29) 1950. (3) Ross, S., and others: J.A.M.A. *142*:1331 (April 29) 1950.

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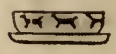
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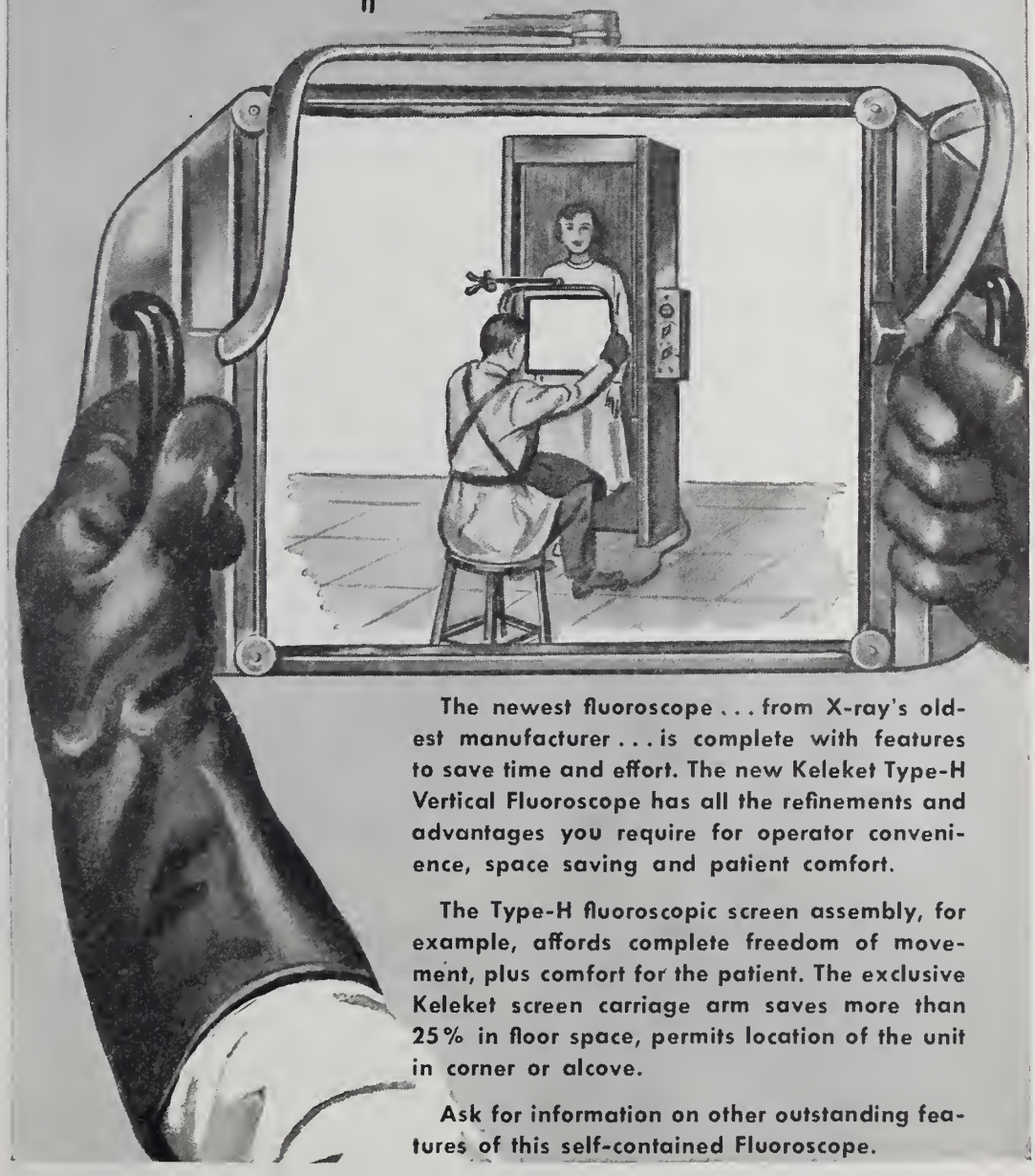
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Meat and its applicability in the Dietary Management of Atherosclerosis

Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

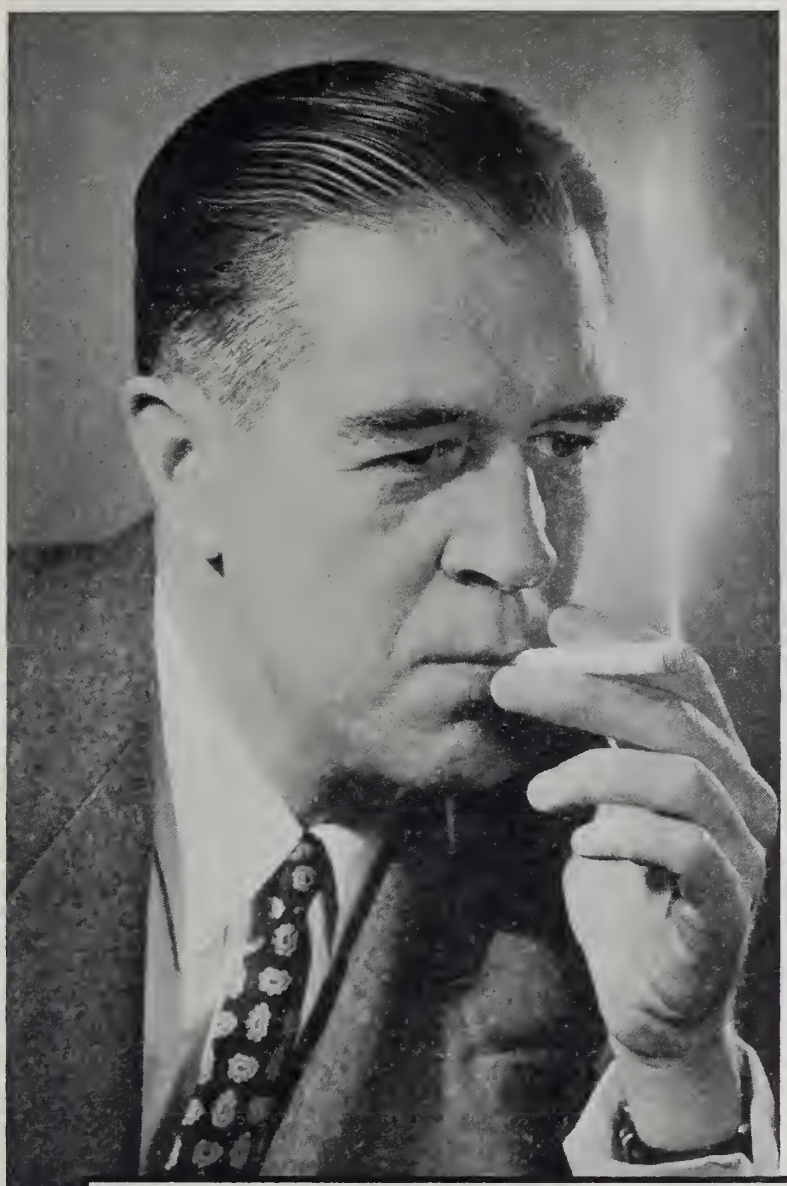
Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

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5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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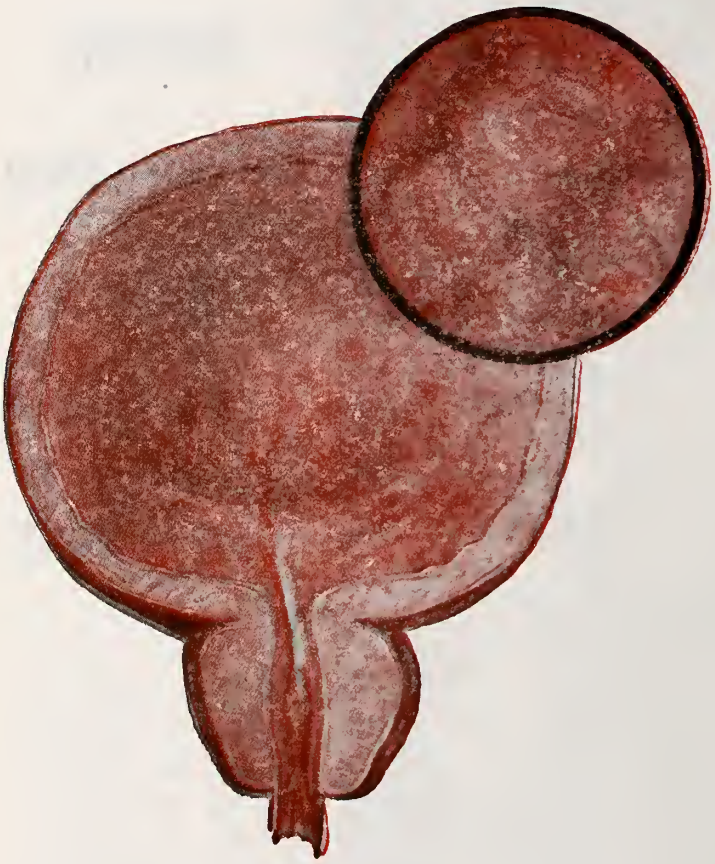
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Blahey, P. R.: Canad. M.A.J. 66:151 (Feb.) 1952.

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*Matthews, J. G.: Care and Healing of Traumatic Wounds. *Northwest Med.*, 50:512, July, 1951

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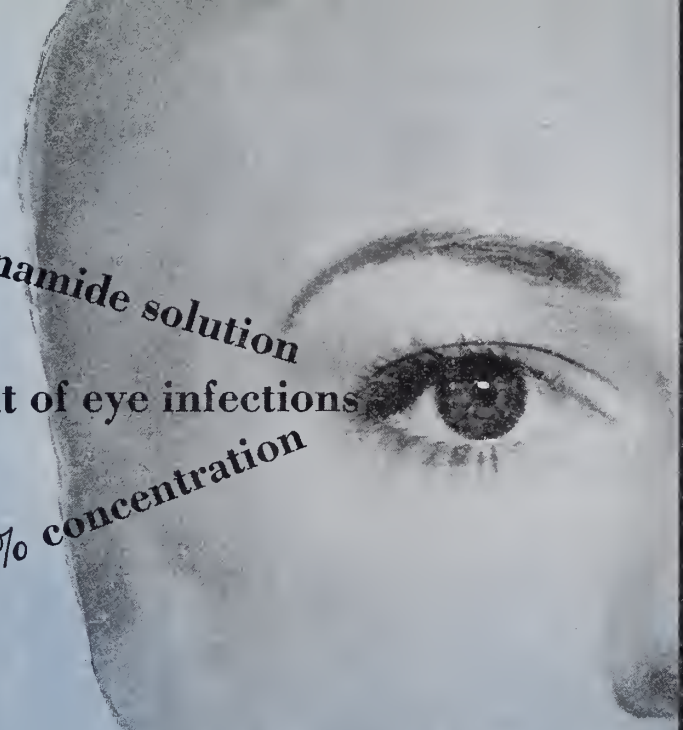
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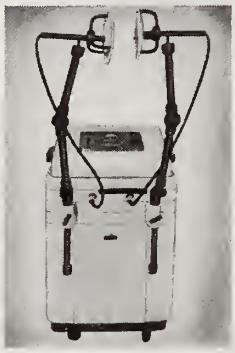
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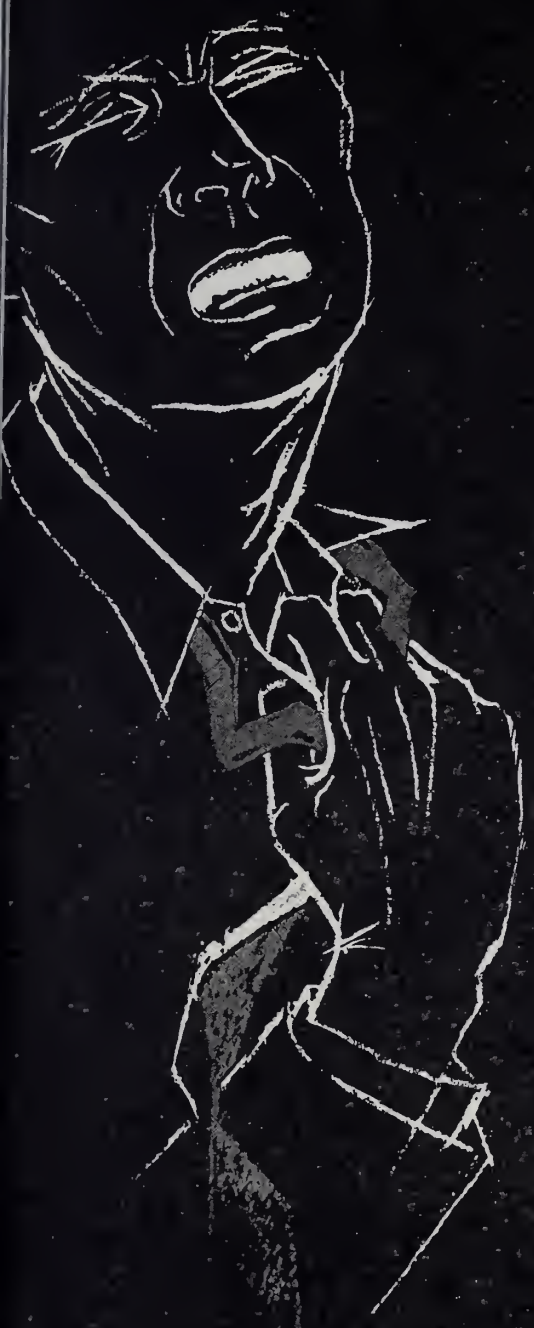
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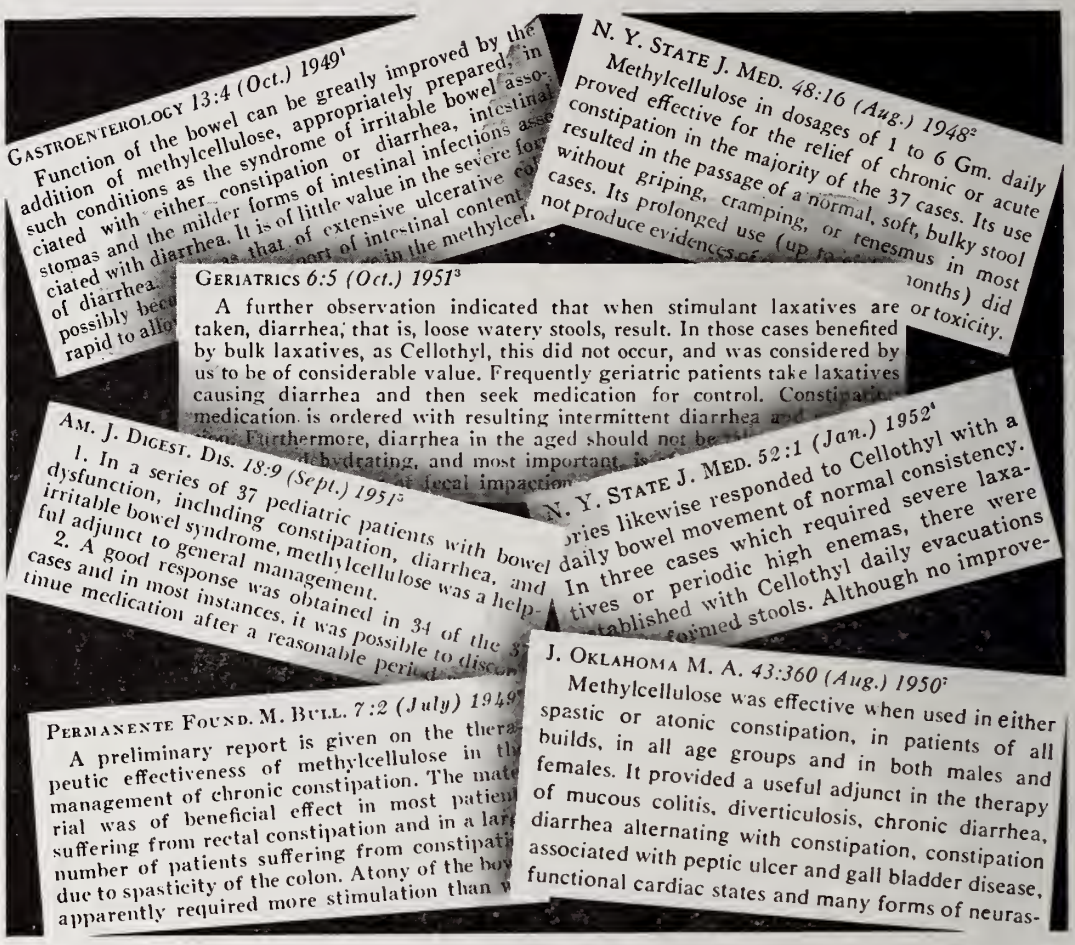
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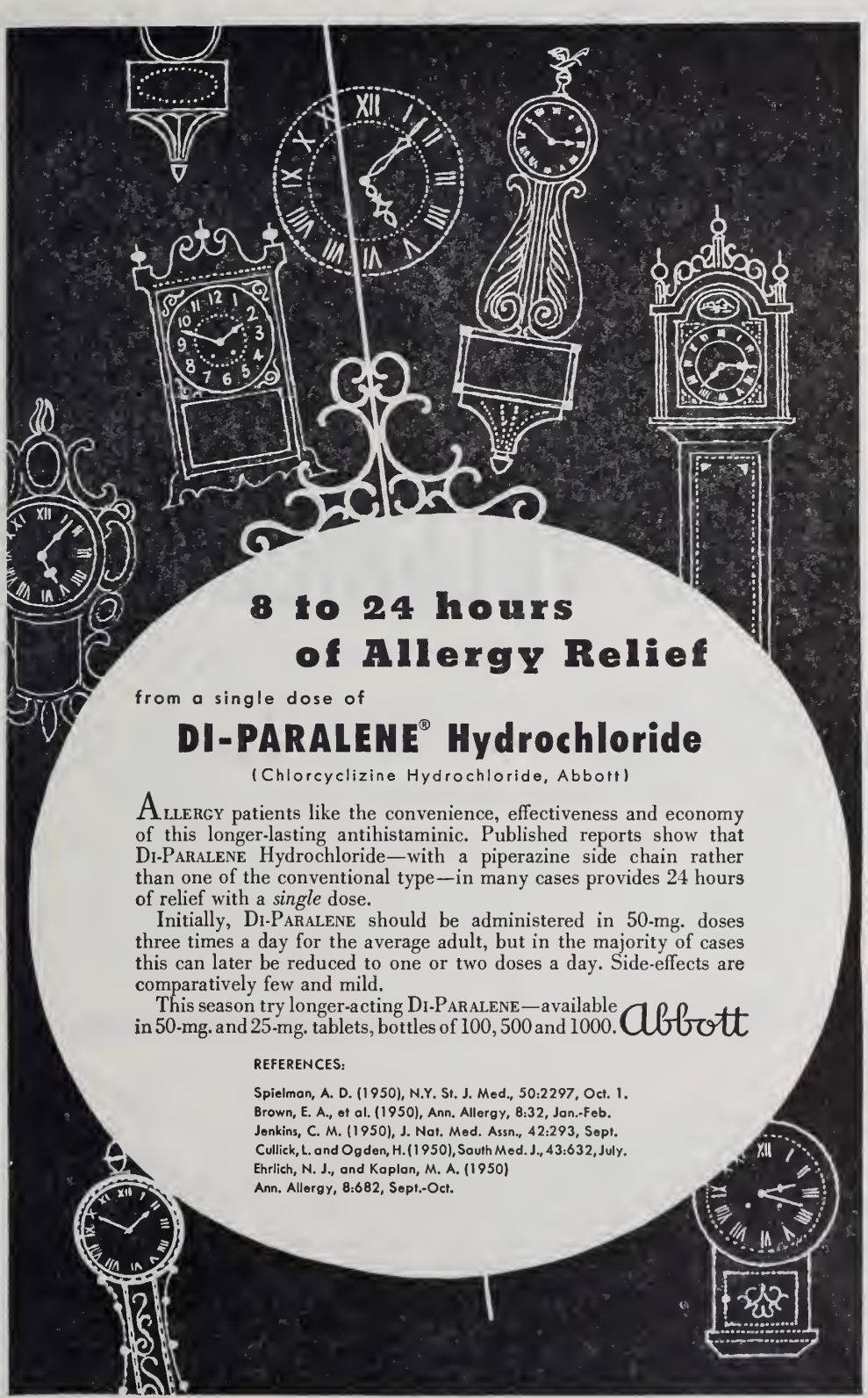
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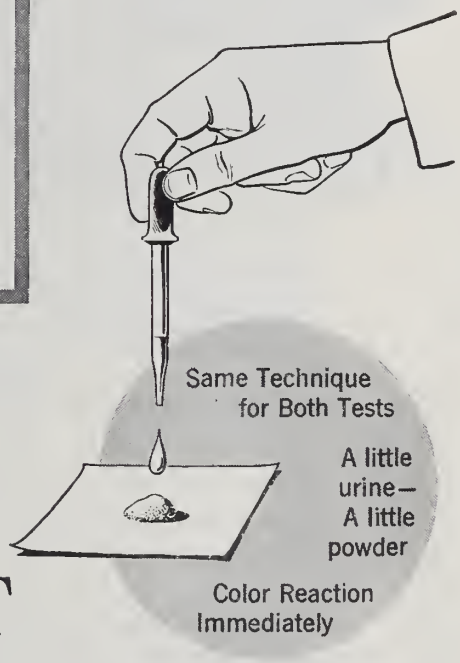
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"Cortisone"—J. M. Carlisle, M.D., A. Gibson, M.D., E. Schmotollo, M.D. —Postgraduate Medicine, Aug., 1950.

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"Cortisone and ACTH—A Review of Certain Physiologic Effects and Their Clinical Implications" — Rondoll G. Sprague, M.D.—American Journal of Medicine, May, 1951.



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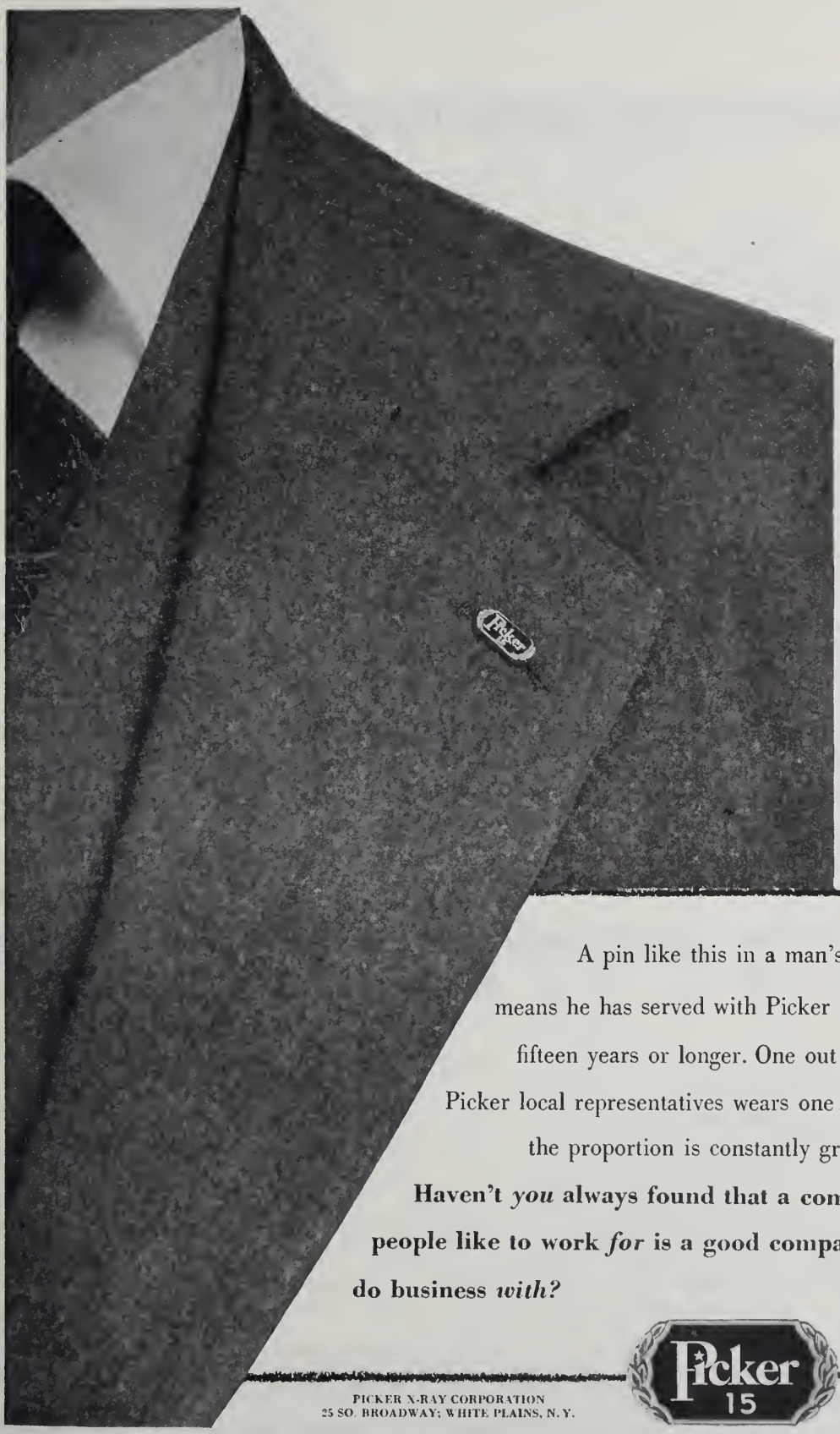
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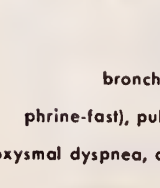
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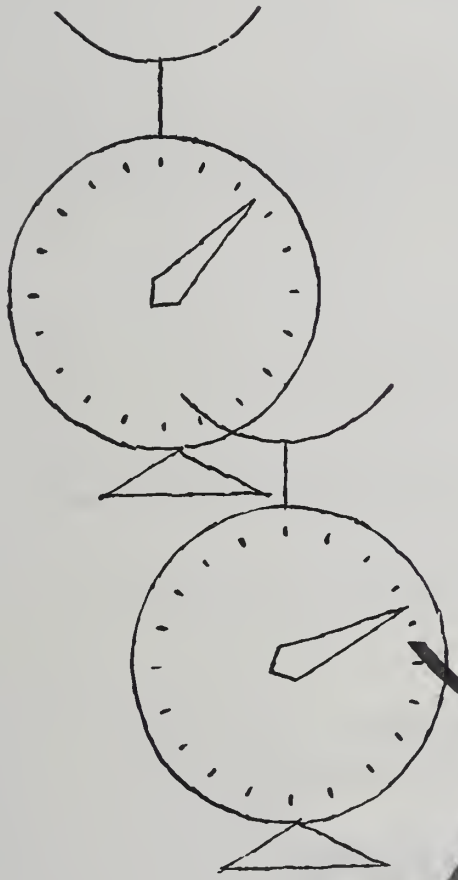
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1 Gordner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texas State J. M. 38:551, 1943
3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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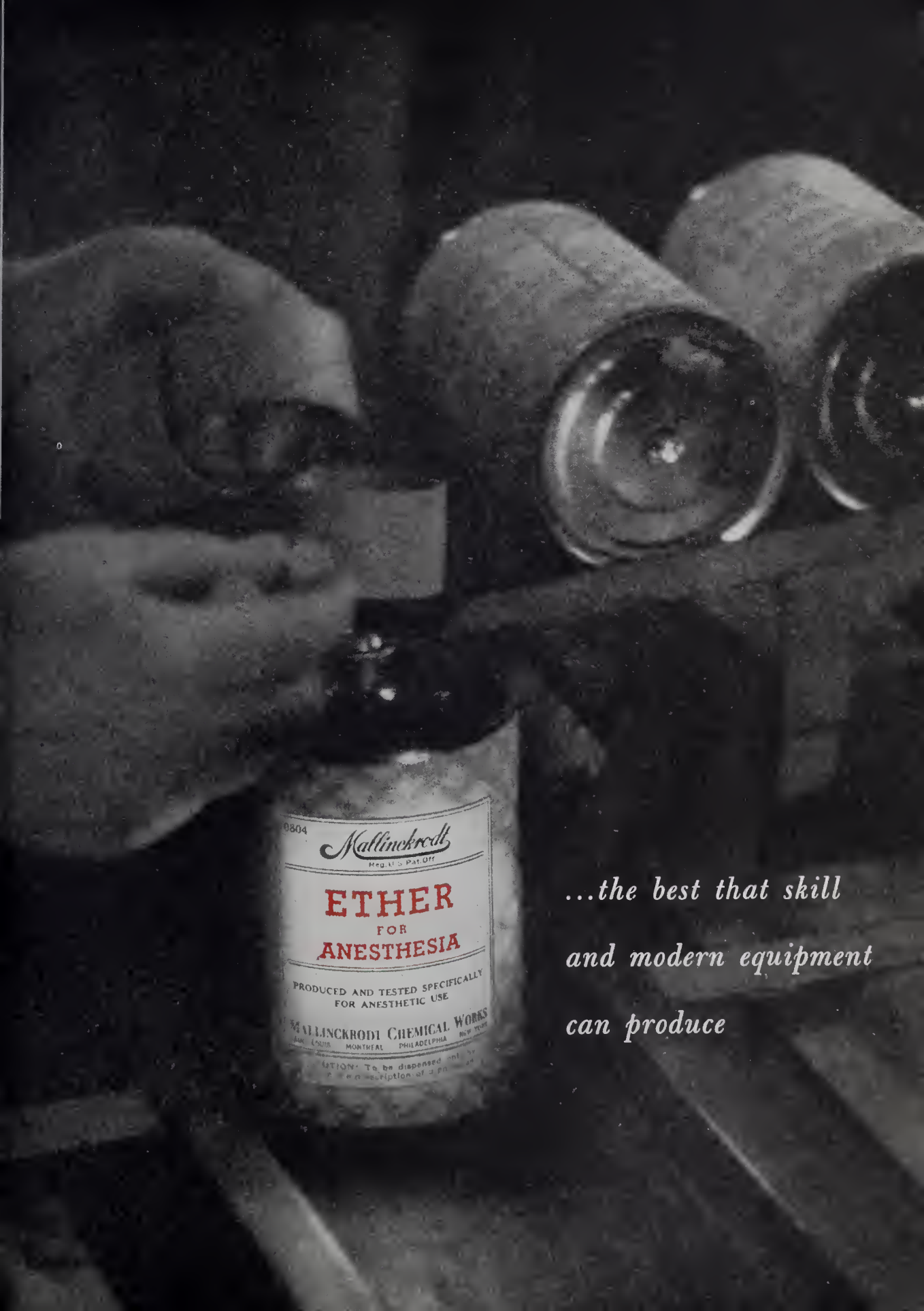
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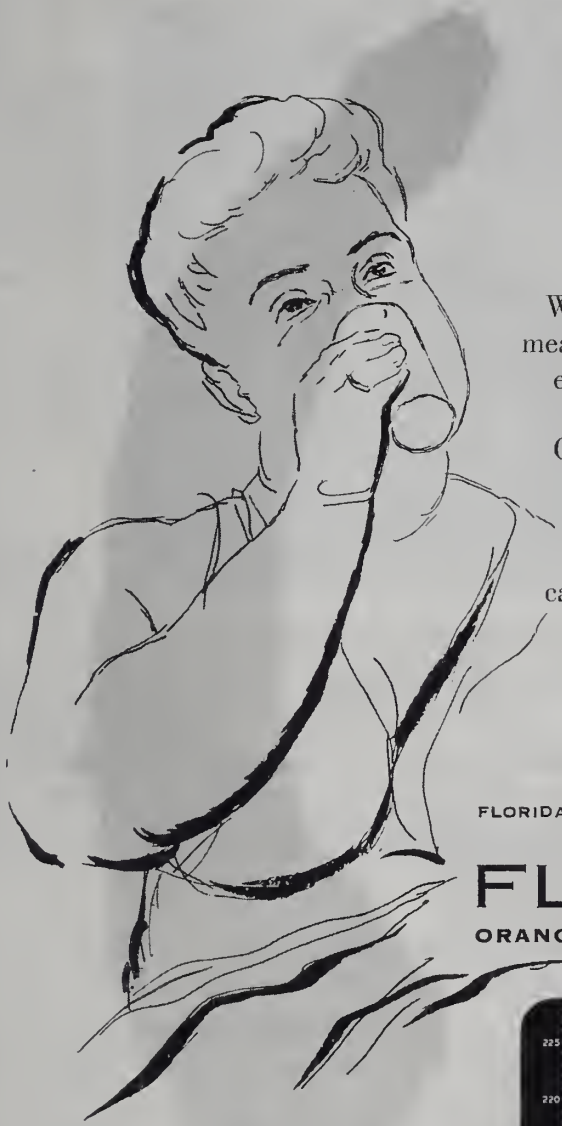
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* *Postgrad. Med. 9:106, 1951.*

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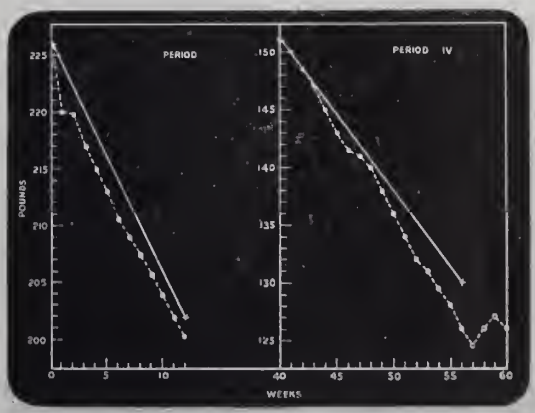
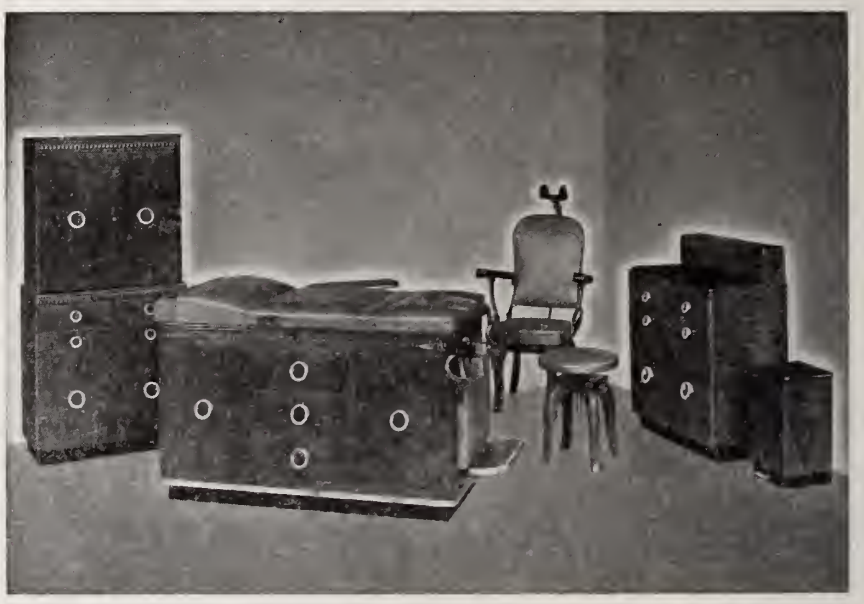


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OF
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UNDER THE DIRECTION OF THE
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PRESIDENT'S MESSAGE

Many conflicting emotions manifest themselves as I write this last message as your President. When I look back to my presidential address I realize too fully how far short of fulfillment our program has fallen. I realize too, my own many shortcomings. However, this presidential year has been a year of great pleasure and a most memorable one for me.

I have had throughout the full cooperation of all our committees; no one has ever refused an assignment. The work of our Society has proceeded in an orderly harmonious fashion.

Several personal convictions have been strengthened during the year. The first is that the practice of medicine in the state of New Jersey is in good hands. When you see hundreds of physicians giving their time and energies to solving the problems of medicine for the people of New Jersey—and you have the experience of observing their deliberations and of seeing the nature of the solutions they propose—you know that the private practice of medicine is in good hands.

Another conviction that has been strengthened is that the practice of medicine will remain in these same good hands.

A third conviction is that our system of the private practice of medicine offers to the people of New Jersey the best type of medical care of any system which has to this date been proposed. Personal free choice of physician on the part of the patient, and a free, open, and confidential relationship between patient and physician are provided. Both of these are essential to satisfactory medi-

cal care from the patient's viewpoint as well as the physician's.

A fourth conviction is that the economic problems which have been weighing so heavily on our patients and physicians, are being solved in an orderly, progressive and satisfactory manner. Our voluntary prepayment plans for medical and hospital care are progressing in a very satisfactory way and are proving of increasing effectiveness in meeting the costs of illness and hospitalization.

Our relations with other professional organizations and health agencies are developing into constructive cooperative efforts which bode well for the future.

It is therefore a pleasure to relinquish my presidential duties to our incoming president, Dr. Harrold Murray, and to wish him well as he assumes the responsibilities of his office. I am certain he will receive the same wholehearted cooperation from all elements of our Society as I did, and that under his able leadership we will continue our progress toward the solution of our many problems.

Sigurd W. Johnsen, M.D.

BLOOD COAGULATION AND DRUGS

Nothing is more stimulating to the medical profession than a good scientific controversy. Violent eruptions can confidently be predicted as a result of Macht's paper[1] on the influence of drugs and emotions on blood coagulation. During animal experiments using cats and rabbits, he reports that a variety of drugs (including some digitalis glycosides, mercurial diuretics, penicillin, antiluetic arsenicals, psyllium seeds and the amphetamines) produced an acceleration of blood coagulation, with a decrease in clotting time. He cites a few clinical reports in which increased incidence of pulmonary embolism occurred in patients receiving one or another of these drugs, particularly digitalis preparations. Although Macht does not specifically recommend that digitalis, penicillin, et cetera, be discarded as harmful drugs, one cannot help but conclude that at least in his opinion they are not without danger because of their hypercoagulation activity.

Granting that in the test tube certain drugs do shorten the coagulation time of blood, one should be circumspect about concluding that such *in vitro* alterations are necessarily of clinical significance. Certainly the evidence that pulmonary embolism is more common in patients receiving digitalis is not very convincing. Patients are usually treated with digitalis for the management of congestive failure, and it is precisely these patients who are most likely to develop phlebothrombosis of the leg veins, from which an embolus may be thrown off to the lungs. Moreover, millions of patients are treated each year with digitalis, penicillin, amphetamines, and mercurial diuretics, yet the proportion of pulmonary embolism is infinitesimal. Surely, if these drugs consistently altered the coagulability of blood to a significant degree, the incidence of thrombo-embolic complications would become staggering.

Macht's researches deserve encouragement and expansion, for they are contributing to our knowledge of the mechanism of blood clotting. However, conclusions reached in the research laboratory should not be applied hastily to the bedside. Drugs of such great and proved value as those he has investigated must not be cast aside on such tenuous evidence of their danger.

1. Macht, D. I.: Influence of Some Drugs and of Emotions on Blood Coagulation. Journal of the American Medical Association, 148:265, (January 26, 1952).

THE 186th ANNUAL MEETING
OF
THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY
MAY 19, 20 and 21, 1952

DAILY SCHEDULE

SUNDAY, MAY 18, 1952

3:00 p. m.—Registration Opens
Lounge Floor

4:00 p. m.—Board of Trustees
Bakewell Room, First Floor

6:30 p. m.—Auxiliary Fellowettes' Dinner
Mandarin Room, Thirteenth Floor

MONDAY, MAY 19, 1952

10:00 a. m.—House of Delegates
Vernon Room, Lounge Floor

12:00 noon—Luncheons:
Section on Neuropsychiatry
Room 1344, Thirteenth Floor
Section on Clinical Pathology
Room 1333, Thirteenth Floor
New Jersey Medical Women's Association
Room 1337, Thirteenth Floor
Medical-Surgical Plan
Porches A and B, Chalfonte

1:00 p. m.—Auxiliary Pre-Convention Board Meeting
Mandarin Room, Thirteenth Floor

2:00 p. m.—Section on Medicine
Vernon Room, Lounge Floor
Section on Clinical Pathology
Viking Room, Thirteenth Floor
Section on Neuropsychiatry
West Room, Thirteenth Floor

3:00 p. m.—Auxiliary Informal Tea
Rutland Room, First Floor

4:30 p. m.—Nominating Committee
Bakewell Room, First Floor

4:30 p. m.—School Health Services Meeting
Tower Room, Thirteenth Floor

6:30 p. m.—Technical Exhibitors' Party
Rutland Room, First Floor

8:00 p. m.—General Session
Vernon Room, Lounge Floor

TUESDAY, MAY 20, 1952

9:00 a. m.—Auxiliary General Session
Mandarin Room, Thirteenth Floor

9:30 a. m.—Reference Committee "A"
Bakewell Room, First Floor
Reference Committee "B"
Rowsley Room, First Floor
Section on Obstetrics and Gynecology
Vernon Room, Lounge Floor
Section on Pediatrics
Viking Room, Thirteenth Floor
Section on Metabolism
West Room, Thirteenth Floor

11:00 a. m.—Reference Committee "C"
Bakewell Room, First Floor
Reference Committee "D"
Rowsley Room, First Floor

12:00 noon—Luncheons:
Section on Pediatrics
Room 1344, Thirteenth Floor
Section on Orthopedic Surgery
Room 1333, Thirteenth Floor
New Jersey Society of Anesthesiologists
Room 1337, Thirteenth Floor
Section on Metabolism
Porch B, Chalfonte
New Jersey Rheumatism Association
Roberts Room, Chalfonte
New Jersey Chapter, American College of Chest Physicians
Blue Room, Chalfonte

12:30 p. m.—House of Delegates (election)
Vernon Room, Lounge Floor
Auxiliary Luncheon
Rutland Room, First Floor

2:00 p. m.—Reference Committee "E"
Bakewell Room, First Floor
Reference Committee on Constitution and By-Laws
Rowsley Room, First Floor
Section on Orthopedic Surgery
Vernon Room, Lounge Floor
Section on Eye, Ear, Nose and Throat
Viking Room, Thirteenth Floor
Section on Anesthesiology
West Room, Thirteenth Floor

3:00 p. m.—Auxiliary General Session (continued)
Mandarin Room, Thirteenth Floor

3:30 p. m.—Reference Committee on Miscellaneous Business
Bakewell Room, First Floor
Reference Committee on Resolutions and Memorials
Rowsley Room, First Floor

4:30 p. m.—New Jersey Orthopaedic Society Business Meeting
Room 1333, Thirteenth Floor
New Jersey Society of Physical Medicine Business Meeting
Room 1337, Thirteenth Floor

6:30 p. m.—Presidents' Reception
Rutland Room, First Floor

7:30 p. m.—Dinner-Dance
Vernon Room, Lounge Floor

WEDNESDAY, MAY 21, 1952

9:00 a. m.—Auxiliary Inaugural Breakfast
Mandarin Room, Thirteenth Floor

9:30 a. m.—House of Delegates
Vernon Room, Lounge Floor

10:00 a. m.— Auxiliary Post-Convention Board Meeting
Mandarin Room, Thirteenth Floor

12:00 noon—Luncheons:
Radiological Society of New Jersey
Room 1333, Thirteenth Floor
New Jersey Chapter, American College of Surgeons
West Room, Thirteenth Floor
Information and organization meeting of New Jersey Chapter

2:00 p. m.—Section on General Practice
Vernon Room, Lounge Floor
Section on Surgery
Rutland Room, First Floor

3:30 p. m.—Exhibits Close
Lounge Floor

4:30 p. m.—Registration Closes
Lounge Floor

GENERAL SESSION

Monday Evening, May 19, 1952

8:30 p. m.

Vernon Room, Lounge Floor

Presiding: Dr. Sigurd W. Johnsen, President

National Anthem

Invocation
Reverend Harvey Bennett, D.D., Presbyterian Church, Atlantic City

Welcome
Honorable Joseph Altman, Mayor of Atlantic City

Musical Selections

Inaugural Address
Dr. Harrold A. Murray, President-Elect

Solo

The Dangers We Face
Honorable Harry B. Cain, United States Senator from the State of Washington

Ushers—Atlantic City Hospital Nurses
Music—Harold Ferrin and Ensemble

SCIENTIFIC SESSIONS

Monday Afternoon, May 19, 1952

SECTION ON MEDICINE

J. JAMES SMITH, M.D., Chairman, Jersey City
CLARENCE B. WHIMS, M.D., Secretary, Ventnor

Vernon Room, Lounge Floor

2:00 p. m.

Clinical Problems in Fluid and Electrolyte Balance
E. Hugh Luckey, M.D., Director, Second (Cornell) Medical Division, New York

2:40 p. m.

Fluid Repair in Diabetic Acidosis
J. James Smith, M.D., Director, Medical Center, Jersey City

3:00 p. m.

Intermission to visit exhibits

3:30 p. m.

Problems in the Differential Diagnosis of Jaundice
Carroll M. Leevy, M.D., Director of Clinical Investigation, Medical Center, Jersey City

3:50 p. m.

Experience with Coronary Thrombosis
Thomas J. White, M.D., Chief of Medical Service, Medical Center, Jersey City

4:10 p. m.

The Diagnosis and Management of Acute Arterial Occlusion
Nathan Frank, M.D., Chief of Peripheral Vascular Disease Clinic, Medical Center, Jersey City

SECTION ON CLINICAL PATHOLOGY

EDWIN H. ALBANO, M.D., Chairman, East Orange
WILLIAM W. HERSOHN, M.D., Secretary, Atlantic City

Viking Room, Thirteenth Floor

2:00 p. m.

Diagnosis and Treatment of the Hemorrhagic Diseases
Nathan Rosenthal, M.D., Attending Hematologist, Mt. Sinai Hospital, New York
Discussor: Sylvan E. Moolten, M.D., New Brunswick

3:00 p. m.
Intermission to visit exhibits

3:30 p. m.
Surgical Indications and Type of Surgical Therapy in Various Splenopathies
Louis M. Rousselot, M.D., Director of Surgery, St. Vincent's Hospital, New York
Discussor: Christopher A. Beling, M.D., Newark

SECTION ON NEUROPSYCHIATRY

ROBERT S. GARBER, M.D., Chairman, Trenton
GEORGE W. HAGER, M.D., Secretary, Camden
West Room, Thirteenth Floor

2:00 p. m.
The Psychiatrist's Role in the General Hospital
Daniel H. Stephenson, M.D., Assistant Psychiatrist, Department of Neuropsychiatry, Cooper Hospital, Camden
Discussor: Michael Vinciguerra, M.D., Elizabeth

2:30 p. m.
Is Stellate Block of Value in Cerebral Vascular Accidents?
Elic A. Denbo, M.D., Chief of Neurology, Cooper Hospital, Camden
Discussor: Thomas S. Fitch, M.D., Plainfield

3:00 p. m.
Intermission to visit exhibits

3:30 p. m.
The Results of 400 Transorbital Lobotomies at the Trenton State Hospital
William W. Wilson, M.D., Medical Director, Fairmount Farms, Philadelphia
Discussor: C. Archie Crandell, M.D., Greystone Park

4:00 p. m.
The Role of the General Practitioner in Modern Psychiatry
Crawford N. Baganz, M.D., Manager, Veterans Administration Hospital, Lyons
Discussor: Evelyn P. Ivey, M.D., Morristown

Tuesday Morning, May 20, 1952

SECTION ON OBSTETRICS AND GYNECOLOGY

BENJAMIN DAVERSA, M.D., Chairman, Spring Lake
JOSEPH E. MOTT, M.D., Secretary, Paterson
Vernon Room, Lounge Floor

9:30 a. m.
Obstetrical Emergencies
John N. Connell, M.D., Attending Obstetrician, Margaret Hague Hospital, Jersey City
Discussor: Robert A. MacKenzie, M.D., Asbury Park

10:15 a. m.
Intermission to visit exhibits

10:45 a. m.
Urinary Stasis and Obstruction in Obstetrics and Gynecology
Houston S. Everett, M.D., Associate Professor of Gynecology, Johns Hopkins University, Baltimore
Discussor: C. Byron Blaisdell, M.D., Asbury Park

11:30 a. m.
Business Meeting

SECTION ON PEDIATRICS

MARTIN A. QUIRK, M.D., Chairman, Red Bank
MARTIN GREEN, M.D., Secretary, Atlantic City
Viking Room, Thirteenth Floor

9:30 a. m.
Treatment of Chronic Pharyngeal Infection and Post-Nasal Drip in Children
Arthur Dintenfass, M.D., Atlantic City Hospital, Atlantic City
Discussor: Warren E. Crane, M.D., Trenton

10:00 a. m.
Administration of ACTH and Cortisone in Rheumatic Heart Disease. Evaluation of Functional Heart Murmurs in Children
Paul A. Kearney, M.D., Rheumatic Fever Unit, St. Michael's Hospital, Newark
Discussor: Harry Green, M.D., Newark

10:30 a. m.
Intermission to visit exhibits

11:00 a. m.
Intestinal Obstruction in Newborn
Thomas V. Santulli, M.D., Surgeon, Columbia-Presbyterian Medical Center, Columbia University, New York
Discussor: Vincent Whalen, M.D., Red Bank

SECTION ON METABOLISM

JOSEPH SKWIRSKY, M.D., Chairman, Newark
GEORGE M. KNOWLES, M.D., Secretary, Hackensack
West Room, Thirteenth Floor

9:30 a. m.
Round Table Discussion on Diabetes
Moderator: Joseph Skwirsky, M.D., Attending Physician, Beth Israel Hospital, Newark

a. Pregnancy and Diabetes
Alexander Ellis, M.D., Assistant Physician, Cooper Hospital, Camden

b. Diabetic Neuropathies
Floyd Fortuin, M.D., Senior Attending in Neurology and Psychiatry, St. Joseph's Hospital, Paterson, and Hans Wassing, M.D., Senior Attending in Neurology and Psychiatry, Barnert Memorial Hospital, Paterson

c. Eye in Diabetes
Ralph E. Siegel, M.D., Attending Ophthalmologist, Perth Amboy General Hospital, Perth Amboy

d. Peripheral Vascular Disorders in Diabetes
Stuart Z. Hawkes, M.D., Chief, Vascular Clinic, Presbyterian Hospital, Newark

10:45 a. m.
Intermission to visit exhibits

11:15 a. m.

Diabetic Coma

Elmer L. Sevringhaus, M.D., Nutley, Clinical Professor of Medicine, New York College of Medicine, New York

Discussor: Jonas Weissberg, M.D., Elizabeth

Tuesday, Afternoon, May 20, 1952

SECTION ON ORTHOPEDIC SURGERY

Paul J. Finegan, M.D., Chairman, Trenton
Raphael R. Goldenberg, M.D., Secretary, Paterson
Vernon Room, Lounge Floor

2:00 p. m.

Symposium on Low Back Pain

Moderator: Elmer P. Weigel, M.D., Chief of Orthopedic Surgery, Muhlenberg Hospital, Plainfield

2:20 p. m.

Diagnosis

John J. Flanagan, M.D., Attending Orthopedic Surgeon, Presbyterian, St. Michael's, and Babies Hospitals, Newark

Discussor: H. Eugene Reading, M.D., Paterson

2:45 p. m.

Conservative and Office Management

Henry H. Kessler, M.D., Chief of Orthopedic Surgery, Hospital for Crippled Children, Newark

Discussor: Frederick G. Dilger, M.D., Hackensack

3:10 p. m.

Intermission to visit exhibits

3:40 p. m.

Operative Treatment

Bernard M. Halbstein, M.D., Chief of Orthopedic Surgery, Monmouth Memorial Hospital, Long Branch

Discussor: Paul J. Finegan, M.D., Trenton

4:05 p. m.

Diagnostic Difficulties

Raphael R. Goldenberg, M.D., Chief of Orthopedic Surgery, St. Joseph's Hospital, Paterson

Discussor: Paul C. Wiesenfeld, M.D., Perth Amboy

SECTION ON EYE, EAR, NOSE AND THROAT

Albert F. Moriconi, M.D., Chairman, Trenton
William H. Hahn, M.D., Secretary, Newark
Viking Room, Thirteenth Floor

2:00 p. m.

Retrolental Fibroplasia

Algernon B. Reese, M.D., Clinical Professor of Ophthalmology, College of Physicians and Surgeons, Columbia University, New York

Discussor: Emanuel Rosen, M.D., Newark

3:00 p. m.

Intermission to visit exhibits

3:30 p. m.

Clinical Significance of Hoarseness

Joseph P. Atkins, M.D., Associate Professor of Broncho-Esophagology, University of Pennsylvania School of Medicine, Phadelphia

Discussor: Albert F. Moriconi, M.D., Trenton

SECTION ON ANESTHESIOLOGY

D'Arcy Clarie, M.D., Chairman, Leonia
Durant K. Charleroy, M.D., Secretary, Trenton
West Room, Thirteenth Floor

2:00 p. m.

Pediatric Anesthesia

C. Ronald Stephen, M.D., Professor of Anesthesiology, Duke University School of Medicine, Durham, N. C.

Discussors: Mildred T. Bohne, M.D., Summit
Anthony P. Vernaglia, M.D., Paterson

3:00 p. m.

Intermission to visit exhibits

3:30 p. m.

Pre-operative Preparation of Patient with Carcinoma

Rodney C. Turner, M.D., Chief, Department of Anesthesia, St. Francis Hospital, Trenton

Discussors: George N. J. Sommer, Jr., M. D., Trenton
Cornelius J. Regan, M.D., Camden

Wednesday Afternoon, May 21, 1952

SECTION ON GENERAL PRACTICE

Edwin Rosner, M.D., Chairman, Collingswood
Sidney D. Becker, M.D., Secretary, Keyport
Vernon Room, Lounge Floor

2:00 p. m.

Treatment of Heart Disease in Childhood

Rachel Ash, M.D., Chief Cardiologist, Children's Hospital, Philadelphia

Discussors: Max L. Weimann, M.D., Camden
Edwin N. Murray, M.D., Camden

3:00 p. m.

Intermission to visit exhibits

3:30 p. m.

Some Chronic Pulmonary Disease Problems in General Practice

Samuel Cohen, M.D., Chief, Medical Division II, B. S. Pollak Hospital for Chest Diseases, Jersey City

Discussors: Alan J. Stolow, M.D., Somerville
Richard R. Chamberlain, M.D., Maplewood

4:00 p. m.

The Borderline Psychotic in General Practice

George W. Hager, Jr., M.D., Neuropsychiatrist, Cooper Hospital, Camden

Discussor: Robert E. Bennett, M.D., Trenton

4:30 p. m.

Treatment of Tuberculosis with Hydrazine Derivatives of Iso-Nicotinic Acid

Irving Selikoff, M.D., Associate Attending Physician, Barnert Memorial Hospital, Paterson, and Seaview Hospital, Staten Island, N. Y.

SECTION ON SURGERY

STUART Z. HAWKES, M.D., Chairman, Newark
H. WESLEY JACK, M.D., Secretary, Camden
Rutland Room, First Floor

2:00 p. m.

Cancer of the Breast

Surgeon—Cushman Davis Haagensen, M.D., Associate Professor of Clinical Surgery, Columbia University, New York

Radiotherapist—Maurice Lenz, M.D., Professor of Clinical Radiology, Columbia University, New York

Pathologist—Arthur Purdy Stout, M.D., Professor of Pathology, Columbia University, Pathologist, Francis Delafield Hospital, New York

2:30 p. m.

Panel Discussion on Cancer of the Breast
Dr. Haagensen, Dr. Lenz and Dr. Stout

3:00 p. m.

Intermission to visit exhibits

3:30 p. m.

Polyposis of the Large Bowel
Paul M. Mecray, Jr., M.D., Attending Surgeon, Cooper Hospital, Camden

4:00 p. m.

Report on Cardiac Surgery
Anthony Crecca, M.D., Attending Thoracic Surgeon, St. Michael's Hospital, Newark

Discussion: Medical Aspects
Nicholas A. Antonius, M.D., Newark
Surgical Aspects
John J. McGuire, M.D., Newark

PRESIDENTS' RECEPTION

Tuesday Evening, May 20, 1952
Rutland Room, First Floor

6:30 p. m.

Honoring the President of the Woman's Auxiliary, MRS. THOMAS H. MCGLADE, and the President of The Medical Society of New Jersey, DR. SIGURD W. JOHNSEN.

PRESIDENTIAL PROMENADE

7:30 p. m.

From Reception to Dinner-Dance

DINNER-DANCE

in honor of

PRESIDENT AND MRS. SIGURD W. JOHNSEN

Vernon Room, Lounge Floor

Toastmaster: Mr. Richard I. Nevin
Welcome: Mrs. Thomas H. McGlade, President, Woman's Auxiliary
Introductions: Mrs. Edward H. Dyer, President-Elect, Woman's Auxiliary
Dr. Harrold A. Murray, President-Elect
Presentation of Fellow's Key:
To: Dr. Sigurd W. Johnsen, President
By: Dr. Aldrich C. Crowe, Junior Past-President

WHAT KIND OF GOVERNMENT DO WE WANT?

Honorable Walter H. Judd, M.D., United States Congressman from Minnesota

Music—Joseph Sterns' Orchestra

Note: Your dinner ticket stub will be your ticket of admission to the reception

HOUSE OF DELEGATES

Presiding Officer, SIGURD W. JOHNSEN, M.D., President, Passaic
Secretary, MARCUS H. GREIFINGER, M.D., Newark
Parliamentarian: DAVID B. ALLMAN, M.D., Atlantic City
Sergeants-at-Arms: BENJAMIN F. LEE, M.D., Camden
GEORGE A. CORIO, M.D., Trenton

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Vernon Room, Lounge Floor

First Session: 10:00 a.m., Monday, May 19, 1952

Order of Business

1. Call to Order
2. Organization of House of Delegates
3. Minutes of 1951 Meeting
4. Introduction of Delegates from Other States
5. Annual and Supplemental Reports
6. New Business
7. Announcements

11:00 a.m.

Tenth Anniversary Celebration of Medical-Surgical Plan

1. Address—L. Howard Schriver, M.D., President, Blue Shield Medical Care Plans, Inc.
2. Award—Mr. Frank E. Smith, Executive Director, Blue Shield Commission
3. History—Irving P. Borsher, M.D., Executive Vice-President and Medical Director, Medical-Surgical Plan of New Jersey
4. Citation—The Medical Society of New Jersey

Second Session: 12:30 p.m., Tuesday, May 20, 1952

Order of Business

1. Report of Nominating Committee
2. Election

Third Session: 9:30 a.m., Wednesday, May 21, 1952

Order of Business

1. Reports of Reference Committees
2. Unfinished Business
3. Installation of Incoming President
4. Adjournment

REFERENCE COMMITTEES

Reference Committee "A"
9:30 a.m., Tuesday, May 20, 1952
Bakewell Room, First Floor
Reports of
The President
The Board of Trustees
The Secretary
The Judicial Council
The Executive Officer

Reference Committee "B"
9:30 a.m., Tuesday, May 20, 1952
Rowsley Room, First Floor
Reports of
The Treasurer
The Finance and Budget Committee
The Publication Committee

Reference Committee "C"
11:00 a.m., Tuesday, May 20, 1952
Bakewell Room, First Floor
Reports of
The Medical Service Administration
The Medical-Surgical Plan
The Emergency Education Program Committee

Reference Committee "D"
11:00 a.m., Tuesday, May 20, 1952
Rowsley Room, First Floor
Reports of
The Medical Defense and Insurance Committee
The Scientific Work Committee
The Advisory Committee to the Woman's Auxiliary
The Medical Education Committee
The New Jersey State Board of Medical Examiners

Reference Committee "E"
2:00 p.m., Tuesday, May 20, 1952
Bakewell Room, First Floor
Reports of
The Welfare Committee
The Subcommittees of the Welfare Committee
The Advisory Committees to the Subcommittees of the Welfare Committee
The Special Committee on Medical School of the Welfare Committee

Reference Committee on Constitution and By-Laws
2:00 p.m., Tuesday, May 20, 1952
Rowsley Room, First Floor
Amendments to the Constitution
Amendments to the By-Laws

Reference Committee on Miscellaneous Business
3:30 p.m., Tuesday, May 20, 1952
Bakewell Room, First Floor
Reports of
The Annual Meeting Committee
The Subcommittee on Scientific Program
The Subcommittee on Scientific Exhibits
The Place and Dates for the 1953 Annual Meeting
Miscellaneous Business

Reference Committee on Resolutions and Memorials

3:30 p. m., Tuesday, May 20, 1952
Rowsley Room, First Floor

Reports of
The Honorary Membership Committee
Nominations for Emeritus Membership
Resolutions
Memorials

Reference Committee on Credentials

Meets at Registration Desk each morning of the meeting.

THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

TWENTY-FIFTH ANNUAL MEETING

Sunday, May 18, 1952

6:30 p. m.—Fellowettes' Dinner (by invitation only)
Mandarin Room, Thirteenth Floor

Monday, May 19, 1952

10:00 a. m.—Registration, Breakfast, Luncheon and Dinner Tickets
Lounge Floor

1:00 p. m.—Pre-Convention Board Meeting
Mandarin Room, Thirteenth Floor

3:00 p. m. to 4:30 p. m.—Tea Honoring Atlantic County Auxiliary Members
Rutland Room, First Floor
"Twenty-Five Years"—
Mrs. Oswald R. Carlander
Guest — Mrs. Harold F. Wahlquist, President, Woman's Auxiliary to the American Medical Association

8:00 p. m.—General Session of the 186th Annual Meeting of The Medical Society of New Jersey
Vernon Room, Lounge Floor
The members of the Woman's Auxiliary are cordially invited to attend.

Tuesday, May 20, 1952

9:00 a. m.—Registration, Breakfast, Luncheon and Dinner Tickets
Lounge Floor

9:00 a. m.—General Session
Mandarin Room, Thirteenth Floor
Order of Business
a. Invocation:
Reverend George W. Lawrence, D.D., Pastor, The Ventnor Community Church
b. Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association:
Mrs. R. John Cottone, Immediate Past-President
c. Welcome:
Mrs. Matthew Molitch, President, Woman's Auxiliary to the Medical Society of Atlantic County
d. Response:
Mrs. Edward H. Dyer, President-Elect
e. Memorial Service for Departed Members:
Mrs. William E. Dodd
f. Reports
g. The Mid-Century Challenge to American Democracy
Mr. James F. Murray, Jr., New York City

12:30 p. m.—Luncheon Honoring Mrs. Thomas H. McGlade, President
Rutland Room, First Floor
Toastmistress: Mrs. David B. Allman
Greetings: Dr. Sigurd W. Johnsen, President, The Medical Society of New Jersey
Guest Speaker: Dr. Ernest B. Howard, Assistant Secretary, American Medical Association, and Adviser to the National Auxiliary
Presentation of President's Pin:
To: Mrs. Thomas H. McGlade, President
By: Mrs. R. John Cottone, Junior Past-President

3:00 p. m.—General Session (continued)
Mandarin Room, Thirteenth Floor
Order of Business
h. Reports and Discussions
i. Report of Nominating Committee
j. Election of Officers

6:30 p. m.—Presidents' Reception Honoring Mrs. Thomas H. McGlade, President of the Woman's Auxiliary, and Dr. Sigurd W. Johnsen, President of The Medical Society of New Jersey
Rutland Room, First Floor

7:30 p. m.—Dinner-Dance Honoring President and Mrs. Sigurd W. Johnsen
Vernon Room, Lounge Floor

Wednesday, May 21, 1952

9:00 a. m.—Inaugural Breakfast
Mandarin Room, Thirteenth Floor
Speaker: Dr. Harrold A. Murray, President-Elect, The Medical Society of New Jersey

10:00 a. m.—Post-Convention Board Meeting
Mandarin Room, Thirteenth Floor
Mrs. Edward H. Dyer presiding

There will be an instruction session for new State Officers, Chairmen and County Presidents immediately following the Post-Convention Board meeting.

EDUCATIONAL EXHIBITS

Gallery, Lounge Floor

Booth 1—Heart Quiz—New Jersey Heart Association, Inc., Newark, N. J.—A question and answer exhibit about diseases of the heart and circulatory system. When you push the correct button the heart marked "yes" lights up to read "right" and a beautiful mellow chime rings out.

If you push the wrong answer button, you get the raspberry chime and the heart marked "no" lights up to reveal that you are wrong.

Heart Quiz pamphlets, together with request cards for other publications of the American Heart Association are given to each person visiting the exhibit.

Booth 2—Cancer Clinics in New Jersey—American Cancer Society, New Jersey Division, Inc., Newark, N. J.

Booth 3—The New Jersey Formulary—Joint Committee on Professional Relations, Trenton, N. J. —Preparations devised by the Joint Committee on Professional Relations will be featured with special attention to flavor and colors of prescription medications.

Booth 4—Medical-Surgical Plan of New Jersey, Newark, N. J.—Medical-Surgical Plan of New Jersey is marking the completion of its first ten years of growth and development in service to the people and the medical profession of New Jersey. Organized by The Medical Society of New Jersey in 1942, the Plan is now helping nearly 700,000 people to meet their medical bills.

This exhibit is offered for the information of the more than 5000 Participating Physicians in New Jersey whose cooperation makes it possible for Medical-Surgical Plan to render an increasing service to the public and the profession.

Booth 5—Guild Provides National Dispensing Service Based on Medical Standards—Guild of Prescription Opticians of New Jersey, Newark, N. J.— Map of United States showing members. Plaque giving the purpose of the Guild. Automatic slide projector showing proper compounding and fitting of eyeglasses. Articles and booklets on eyecare of interest to the General Practitioner will be distributed. Free adjustment of eyeglasses for Members and visitors will be provided.

Booth 6—New Jersey Department of Institutions and Agencies, Trenton, N. J.—The purpose of this exhibit is to show how the New Jersey Department of Institutions and Agencies has administered the $25,000,000 fund made available to it by the 1949 bond issue referendum. Representative projects at the State institutions highlight a building and modernization program intended to relieve bad overcrowding.

SCIENTIFIC EXHIBITS

Garden Room

Booth 1—The Management of the Third Stage of Labor Employing a Combination of Pitocin and Methergine—Herschel S. Murphy, M.D., Rahway Hospital, Rahway.

We describe a method of delivery using Pitocin[1] and Methergine.[2] In this way, the physician with one nurse can completely manage delivery and adequately take care of both the mother and child. We describe the actions of Pitocin[1] and Methergine.[2] The makeup of our group such as, age, type of delivery, and blood loss are also shown.

Booth 2—Etiology of Varicose Veins—Sherman A. Eger, M.D., and Frederick B. Wagner, Jr., M.D., Jefferson Medical College and Hospital, Philadelphia.

This presents new information about the etiology of varicose veins of the lower extremities, using charts, photographs and photomicrographs. Constitutional defects in venous structure are enumerated and illustrated from 200 dissections and histologic studies. It is concluded that these defects are the primary factors in the etiology of varicose veins, whereas mechanical factors merely play a contributory or aggravating role.

Booth 3—Vulvectomy—A. H. Marbach, M.D., and L. H. Schinfeld, M.D., Graduate School of Medicine, University of Pennsylvania and Jewish Hospital, Philadelphia; and George D. Richardson, Ortho Research Foundation, Raritan.

The new technic of doing vulvectomy by high frequency knife.

Booth 4—Simplified Technic of Total Abdominal Hysterectomy—Ernest F. Purcell, M.D., McKinley Hospital, Trenton.

Charts and colored photographs show in detail the various steps in operative procedure. Emphasis is placed on ligation of the uterine blood supply and dissection of the trans-cervical fascia from the anterior and the posterior wall of the cervix. This enables mobilization of the cervix, without danger or injury to the ureters. Preservation of the trans-cervical fascia also gives better support for the vaginal vault. Pictures demonstrate use of

1. A purified oxytoxic principle of the posterior lobe of the pituitary prepared by Parke Davis and Company.
2. A methylergonovine tartrate prepared by Sandoz Pharmaceuticals.

the Purcell Retractor to give excellent exposure of the operative field, thereby adding to the simplification of the surgical procedure.

Booth 5—An Anorectoplasty for Complicated and Extensive Hemorrhoids—Emil Granet, M.D., French Hospital, New York.

Commonly one finds extensive hemorrhoids complicated by mucosal prolapse, cryptitis, papillitis, anal stenosis (pectenosis) and perhaps an anal ulcer triad. In such cases no single operation can completely remove all lesions and yet avoid late complications such as anal contracture, fissure and recurrent hemorrhoids.

An operation which combines the best features of the operations of Whitehead, of Gabriel, of Milligan and perhaps others is described and the technic illustrated. This anorectoplasty completely removes all diseased tissue and uniformly results in a normally functioning and dilatable anorectum. Charts, original drawings and colored transparencies are utilized.

Booth 6—Extended Radical Excision for Advanced Cancer of the Rectum: Eviscerectomy with Transplantation of the Ureters—H. E. Bacon, M.D., Lowrein McCrea, M.D., H. D. Trimpi, M.D., I. Sauer, M.D., and C. C. Jackson, M.D., Temple University School of Medicine, Philadelphia.

Color transparencies depict extensive cancer involving the rectum, vagina, bladder, uterus and adnexa. Anatomy of the male and female pelvises with special attention to the lymphatics and blood vessels is demonstrated. The steps in the extended radical operation are illustrated with attention to cystectomy and transplantation of the ureters. The perineal phases of the operation in male and female are given. There is complete review of pre- and postoperative care. Statistics are presented from a series of 1190 cases of cancer of the large bowel. Particular reference is made to 115 cases undergoing extended extirpation procedures for cancer of the rectum. Enlarged color photographs of actual specimens and patients are included.

Booth 7—Cortisone: Specific Therapy in Rheumatic Diseases—Irving L. Sperling, M.D., Newark.

A series of charts and illustrations exhibit practical methods of administering cortisone to patients with arthritis and rheumatic diseases. Definite therapeutic indications are reviewed where there are permanent lasting effects on the disease process. Results with combined gold and cortisone therapy are exhibited.

Booth 8—Evaluation of Cleft Palate Patients—Lyndon A. Peer, M.D., John C. Walker, Jr., M.D., Robert Hagerty, M.D., Michael B. Collito, D.D.S., and F. S. Hoffmeister, D.D.S., Hospital of St. Barnabas, Newark.

This is a pictorial demonstration showing how a patient who has had a cleft palate is evaluated by a group of coordinated departments. Findings of all departments are correlated for the best management of the total patient.

Booth 9—Two Million Volt X-rays in the Treatment of Cancer—Milton Friedman, M.D., Hospital for Joint Diseases, New York.

Supervoltage x-ray apparatuses will be illustrated. Rotation platforms, devices for precision aiming of the beam, and photographic films demonstrating the distribution of radiation in tissue and a photo-electric densitometer will also be shown. Several of these apparatuses are original. The indications, and accomplishments of supervoltage radiation will be described, including follow-up studies.

Booth 10—The Cervix—Edwin H. Albano, M.D., and C. Joseph Ferri, M.D., Columbus Hospital, Newark.

This presents newer methods in the diagnosis and treatment of diseases of the cervix, with particular stress on carcinoma of the cervix. The pathology will be illustrated by charts, Kodachromes and a life-size manikin. The technic of obtaining surface biopsies and Papanicolaou smears will be demonstrated. The exhibit is oriented to the general practitioner as well as to the specialist.

Booth 11—Antimicrobal Spectrum of Thiolutin, Rimocidin and Terramycin—Harry Seneca, M.D., and Jasper H. Kane, M.D., Columbia University, New York.

Two new antibiotics Thiolutin and Rimocidin are presented. The display reviews their spectrum against bacteria, fungi, amebae and flagellates, and comparison with Terramycin is indicated.

Booth 12—Congenital Anterior Chest Wall Deformities of Diaphragmatic Origin—A New Interpretation—Henry A. Brodkin, M.D., Newark.

Chest deformities commonly known as funnel chest, pigeon chest and Harrison's grooves have been considered as due to various unsupported etiologic factors such as rickets, upper respiratory obstruction, intra-uterine pressure, et cetera. This exhibit demonstrates that the common etiologic factor for these deformities is an abnormally developed diaphragm. Charts, specimens of diaphragms and photographs reflect the various types. Two operative procedures are shown for the treatment of congenital chondrosternal depression or funnel chest. For infants who have a mobile chondrosternal inspiratory retraction, a phrenosternolysis is performed. For older children and adults with a fixed chondrosternal depression, a chondrosternoplasty is performed. Pre- and postoperative photographs together with sketches of the procedures are shown.

Solarium

Booth 13—The Significance of Certain Common but Seldom Evaluated Electro-cardiographic Patterns—C. E. Kiessling, M.D., H. B. Kirkland, M.D., and A. M. Lyle, F.S.A., Prudential Insurance Co., Newark.

The exhibit summarizes the results of an analytic

survey of over 15,000 electro-cardiograms on more than 6000 office workers, designed to demonstrate the clinical significance of some frequently-encountered but seldom-evaluated patterns. The impairments considered are premature contractions, marked sinus arrhythmia at the upper ages, prolonged intra-ventricular conduction, complete right and left bundle branch blocks, notched T waves in precordial leads V5 and V6. Accurate correlation of the electrocardiographic findings with the clinical background and course is made possible by the detailed records available. The same source material provides a control group of 750 cases having unequivocally normal tracings.

Booth 14—D-V-A Ballistocardiograph—Sidney R. Arbeit, M.D., Medical Center, Jersey City.

This demonstration of a new ballistocardiograph incorporates electronics for analyzing the body motion in terms of its displacement, velocity and acceleration. The need for, and value of, this additional information is shown mathematically, graphically and in case reports.

Booth 15—A Symbol Observed in Migraine Cases—Theodore S. Heineken, M.D., Bloomfield.

A new sign for the diagnosis of migraine is described. It has been observed in over 88 per cent of a series of migrainous patients. Four case histories are given in which the "horseshoe" sign of migraine was observed. Illustrations are included. This sign, together with the history, will enable the physician to make a definite diagnosis of migraine.

Booth 16—Prantal in the Treatment of Peptic Ulcer—Theodore S. Heineken, M.D., Mountainside Hospital, Montclair.

Three large folders with x-ray pictures and case reports show the use of Prantal,[3] a new drug, similar to Banthine[4] which does not give side or toxic effects.

Booth 17—Syncope (A System of Clinical Study)—Albert Abraham, M.D., Morristown, and Marcus Rosenblum, M.D., Veterans Administration Hospital, Lyons.

This exhibit offers a graphic description of procedures for studying individuals with episodes of syncope. It includes cardiograms, x-rays, electroencephalograms, and similar material. A printed pamphlet containing details of the material outlined on the wall exhibit and containing case histories is available for distribution.

Booth 18—Rehabilitation of the Advanced Chronic Illness or Geriatric Patient—Joseph O. Smigel, M.D., Pine Haven Sanitarium, Pinewald.

The exhibit includes a scale model of our Physical and Hydro-Therapy Department, three statistical charts, a demonstrable devices board and two viewers showing a pictorial representation of the institution. It demonstrates our program of rehabilitation of the advanced chronic illness patient for all groups over 18.

Booth 19—Gastro-enterology in Everyday Practice—New Jersey Gastro-Enterological Society.

The exhibit included spot-film x-rays, gastroscopy, sigmoidoscopy, fluoroscopy, stool examinations, occult blood, ova parasites, chemical analysis, Papanicolaou technic, gastric analysis, diagnostic biliary drainage, pancreatic studies, liver needle biopsies and esophageal dilators.

Booth 20—Miliary and Meningeal Tuberculosis: Therapy and Results—Samuel Cohen, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City.

A group of 25 cases of miliary and/or meningeal tuberculosis admitted during the four year period (1947-1950 inclusive) and treated with antibiotics is reviewed. Results in each group are presented together with suggested plans for therapy. Chemotherapy of these two serious tuberculous complications demands: (1) administration of antibiotics for long periods to prevent relapse; (2) a minimum of toxicity from their use; (3) the lowest possible incidence of drug resistant organisms.

Booth 21—Prevention of Esophageal Stricture by Cortisone—Norman Rosenberg, M.D., Philip J. Kunderman, M.D., Sylvan E. Moolten, M.D., and Leo Vroman, Laboratories of St. Peter's General Hospital, New Brunswick (Aided by a grant from Merck & Co.).

This exhibit demonstrates that large doses of cortisone (Cortone[5]) can prevent the esophageal stricture which ordinarily results, following the experimental production of a localized sodium hydroxide burn of the esophagus.

Control rabbits killed six weeks after injury, show well defined strictures. Almost all animals, treated with cortisone alone failed to show strictures. However, a high incidence of infections, many of them fatal, appeared in the latter group.

Penicillin, simultaneously administered with cortisone to a third group of rabbits, strikingly reduces the incidence of infection, with excellent survival rates being obtained.

Results are demonstrated by enlarged Kodachrome illustrations, graphs, drawings and actual specimens.

Booth 22—Modern Methods of Premature Care—Child Welfare Committee, Essex County Medical Society.

Demonstration of premature incubator and nursery technics, including feeding by indwelling polyethylene gavage tube. Charts indicating advantages of community Premature Center.

Booth 23—Juvenile Endocrinopathies—Rita S. Finkler, M.D., George M. Cohn, M.D., and Sylvia F. Becker, M.D., Beth Israel Hospital, Newark.

This presents the common endocrinopathies encountered in children, and includes various phases of pathologic states of pituitary, thyroid, adrenals, and the gonads. Laboratory investigations and therapies used are discussed.

3. A quaternary ammonium compound prepared by the Schering Corporation.
4. A brand of methantheline prepared by G. D. Searle and Company.
5. Merck and Company's brand of cortisone acetate.

Booth 24—Hyper-Rugosity of the Stomach — Robert Sherman, M.D., Atlantic City and Daniel Wilner, M.D., New York.

This roentgen study demonstrates the presence of giant rugae in the stomach. These have been divided into two types: the localized and the diffuse. The localized type is often incorrectly diagnosed as carcinoma of the stomach, whereas the diffuse or generalized type may closely simulate a lymphoma or polyposis of the stomach. Illustrative cases are displayed showing methods of differential diagnosis.

Booth 25—Perianal Tuberculous Infections in Tuberculous Patients—Diagnosis and Treatment— Julius Gerendasy, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City.

Early radical excision of tuberculous lesions in tuberculous patients will result in a cure. The formulae for anorectal operative procedures in tuberculous patients are: Prompt drainage of perianal abscesses; radical excision of the lesions, saucerization of all wounds, and avoidance of prolonged packing to allow free drainage. Wound infection can be prevented by (a) minimal use of clamps to lessen trauma to tissues; (b) avoidance of mass ligatures; (c) free wound drainage; (d) complete hemostasis; (e) proper care of postoperative wounds. The more common tuberculous lesions and the stages of healing will be illustrated with numerous colored transparencies as well as four posters which summarize the clinical features of this type of infection.

TECHNICAL EXHIBITS

Lounge Floor

Booth A—Medco Products Co., Tulsa, Okla.— The *Medcotron* Stimulator, for the stimulation of innervated muscles or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

Booth B—Doris Appel Medical Sculptures, Lynn, Mass.—This exhibit will present portrait plaques and small portraits—in the round— of Imhotep, Hippocrates, Galen, Maimonides, Vesalius, Pare, Pasteur, Lister, Roentgen, and several others of the great figures in medical history.

Mrs. Appel specializes in medical history sculpture projects, designed for medical schools, hospitals, libraries and institutions.

She has built *The Hall of Medicine* and is now completing a series of panels on the history of *American Medicine.*

The small portraits are now made available to the medical profession.

Booth C—Lissco Medical Company, Inc., Newark, N. J.

Booth D—Baby Development Clinic, Chicago, Ill.—This exhibit presents psychological and emotional aspects of early feeding in visual as well as printed form. Ideal for use of doctors, nurses as well as teachers, and others who are in contact with expectant parents, medical students or nurses in training.

Maternity Counselling Service. . . a courtesy service available to doctors for their maternity patients . . . relieves doctors of discussing layette needs and other preparations for home and baby. No charge or obligation to doctor or patients. Supported by firms included in exhibit.

Booth 1—A. H. Robins Company, Inc., Richmond, Va.—This exhibit is featuring *Donnatal,* sedative-antispasmodic; and *Allbee with C,* capsules supplying "saturation dosage" of the water-soluble vitamins. Robins' Medical Service Representatives welcome the privilege of discussing with physicians attending the Assembly these and other products in the company's line of prescription specialties.

Booth 2—Faulhaber and Heard, Inc., Newark, N. J.—Full particulars can be obtained on the special Professional Liability contract for members of The Medical Society of New Jersey upon inquiry at the booth of the Official Broker, Faulhaber & Heard, Inc.

Individual protection is also available to registered or graduate nurses, x-ray and laboratory technicians and physiotherapists employed by physicians insured.

Those physicians who have not taken advantage of these important features of their membership are advised to confer with our representative.

Booth 3—E. and W. Blanksteen, Jersey City, N. J.—Participation in the State Society's plan of accident and health insurance, underwritten by the National Casualty Company of Detroit, through the State Society's brokers, E. and W. Blanksteen of Jersey City, New Jersey, has reached an all time high as a result of last year's enrollment incorporating the new maximum limit of $600 monthly benefit. In excess of 70 per cent of the eligible members of the State Society are now insured.

Booth 4—The Stuart Company, Chicago, Ill.— Several nutritional specialties will be displayed. There will be special emphasis on three new products just being introduced: *Stuart Hematinic For-*

tified; Stuart Multivitamin Drops with B-12; and *Stuart Amvicel* (a more complete product for obesity control).

Booth 5—Ciba Pharmaceutical Products Inc., Summit, N. J.—We invite you to visit our exhibit which will feature *Pyribenzamine* in the treatment of drug dermatoses, showing the action of this effective antihistaminic when absorbed through damaged skin and by oral administration.

Representatives in attendance will be glad to answer questions about *Pyribenzamine* and other Ciba products used in dermatology.

Booth 6—Picker X-ray Corporation, White Plains, N. Y.—You are invited to visit our exhibit where the latest accessories and equipment available for x-ray work are on display. A staff of technical specialists will be pleased to assist you with any x-ray planning or technical problem.

Booth 7—Sandoz Pharmaceuticals, New York, N. Y.—Physicians attending The Medical Society of New Jersey Convention are cordially invited to visit our display which will feature the following:

Hydergine: A new approach and a new product for hypertension and peripheral vascular diseases.

Cafergot: The first effective oral preparation for the treatment of migraine and related headaches.

Bellergal: A time-tested preparation for use in functional disorders.

A new handbook listing our products will be available and representatives in attendance will gladly answer any questions about these and other Sandoz products.

Booth 8—Desitin Chemical Company, Providence, R. I.—*Desitin Ointment:* the pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

Desitin Powder: a unique, dainty medicinal powder saturated with cod liver oil.

Desitin Hemorrhoidal Suppositories with Cod Liver Oil: coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

Desitin Lotion: the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritis, poison ivy, et cetera.

Booth 9—J. Beeber, Inc., New York, N. Y.

Booth 10—McNeil Laboratories, Inc., Philadelphia, Pa.—Members of The Medical Society of New Jersey are cordially invited to visit our booth, Mr. H. M. Schabacker in charge. The products on exhibit will be *Butisol Sodium, Cinbisal, Syndrox Hydrochloride, Syntil, Butisol-Belladonna* and *Sustinex.*

Booth 11—Pet Milk Sales Corporation, St. Louis, Mo.—Specially trained representatives will be in attendance to discuss the use of *Pet Milk* in infant feeding, and to present many services that are time-savers for busy physicians.

Miniature *Pet Milk* cans will be given to visitors at the exhibit.

Booth 12—Lea & Febiger, Philadelphia, Pa.—Schedule plenty of time to look over our display of such outstanding new books and new editions as: Herbut, *Urological Pathology* (2 volumes); Master, Moser and Jaffe, *Cardiac Emergencies and Heart Failure;* Ritvo and Shauffer, *Gastro-intestinal X-ray Diagnosis;* Collins, *Anesthesiology;* Town, *Ophthalmology;* Lewin on *The Knee;* Warren and LeCompte, *Pathology of Diabetes Mellitus;* Musser-Wohl, *Internal Medicine;* Levinson and MacFate, *Clinical Laboratory Diagnosis;* Eller and Eller, *Tumors of the Skin;* and many other books of current clinical importance.

Booth 13—The Borden Company, New York, N. Y.—Borden representatives will be more than pleased to discuss a new powdered infant food with you. *Bremil* is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted to supply the nutritional requirements of infants deprived of human milk. Clinical, x-ray, and laboratory evidence with a large group of infants fed exclusively on *Bremil* proved conclusively its efficacy as an infant food. *Bremil* is a new phase in infant feeding.

Likewise exhibited will be our long-established products for infant feeding: *Mull-Soy, Dryco, Biolac,* Special Protein, Skimmed, and Lactic Acid Milks, general purpose *Klim,* and *Beta Lactose.*

Booth 14—Clark & Clark, Wenonah, N. J.—*Profetamine R Phosphate Chewing Gum* 10 Mg. (Monobasic Amphetamine Phosphate, Racemic, United States Patents No. 2,507,468, No. 2,536,168) can be used to increase energy . . . elevate the mood . . . combat drowsiness . . . *or in the treatment of obesity.* Clark & Clark products are sold only through the medical profession. Trade packages and samples are available at the booth.

Booth 15—M & R Laboratories, Inc., Columbus, Ohio—Our representatives for *Similac* and *Cerevim* will be most happy to discuss with you the merits and use of our products in the field of infant and child nutrition.

Booth 16—The Doho Chemical Corporation, New York, N. Y.—We are pleased to exhibit *Auralgan,* the ear medication for relief of pain in otitis media and removal of cerumen; *Rhinalgan,* the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the *New Otosmosan,* the effective, non-toxic ear medication which is fungicidal and bactericidal (gram negative—gram positive) in the suppurative and anral dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation is also featuring *Rectalgan,* the liquid topical anesthesia for relief of pain and discomforture in hemorrhoids, pruritus and perineal suturing.

Booth 17—Gerber Products Company, Fremont, Mich.—The *Gerber Baby* greets physicians and their guests at The Medical Society of New Jersey Convention. Symbolizing the best in baby foods, he will continue pioneering research in the field of applied infant nutrition. His picture on "Starting" cereals, Strained and Junior foods and Gerber-Armour meats for babies is your assurance of uniform high quality.

Booth 18—Sharp & Dohme, Inc., Philadelphia, Pa.—Research data relative to the potentiating effect of the antibiotics, *Bacitracin* and *Tyrothricin,* are featured in the Sharp & Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of vitamin B12 are also of major interest. Our representatives will welcome your visit.

Booth 19—Saratoga Springs Authority, Saratoga Springs, N. Y.—The New York State-owned Saratoga Spa presents a new exhibit to emphasize naturally carbonated mineral water treatments. State colors of blue and gold predominate. Exhibit panels include color transparencies showing bath houses and recreational features. Two panels describe facilities for rehabilitation and recreation. Literature will be distributed by an attendant, and geyser water will be served.

Booth 20—Philip Morris and Co. Ltd., Inc., New York, N. Y.—Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that *Philip Morris* are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Booth 21—Smith, Kline and French Laboratories, Philadelphia, Pa.—*Trophite* is a delicious, high-potency elixir of B_{12} and B_1—especially designed to increase appetite and rate of growth. In a recent one-year clinical trial, *Trophite* increased the rate of development of below par children by almost 50 per cent. Each 5 c.c. teaspoonful supplies Vitamin B_{12}, 25 mcg. and Vitamin B_1 10 mg. Available in 4 fl. oz. bottles.

Booth 22—W. B. Saunders Company, Philadelphia, Pa.—You will probably be very interested in the new book on *Recent Advances in Medicine and Surgery,* from the Graduate School of Medicine of the University of Pennsylvania. It's devoted to the type of clinical, postgraduate information that you like.

Other new books available for your inspection: Conn's 1952 *Current Therapy;* Bland's *Clinical Use of Fluid and Electrolyte;* Grishman & Scherlis' *Spatial Vectorcardiography;* Alvarez on the *Neuroses; Lahey Clinical Surgical Practice;* Cecil's *Specialties in General Practice;* Meschan's *Normal Radiographic Anatomy;* Howorth's *Orthopedics;* Slocumb's *Rheumatic Diseases;* New (3rd) Edition of Callander's *Surgical Anatomy;* Kroger & Freed's *Psychosomatic Gynecology;* Tait on *Refraction;* Duncan's *Diabetes Mellitus;* and others.

On hand also, of course, will be such standard works as Cecil & Loeb's *Medicine; American Illustrated Medical Dictionary;* Hyman's *Integrated Practice of Medicine;* Mitchell-Nelson's *Pediatrics;* Greenhill-DeLee's *Obstetrics,* Todd & Sanford's *Clinical Laboratory Diagnosis;* recent numbers of the *Medical and Surgical Clinics of North America;* et cetera.

Booth 23—The Wm. S. Merrell Company, Cincinnati, Ohio—For prompt, effective and comfortable relaxation of gastro-intestinal smooth muscle spasm Merrell presents *Bentyl* Hydrochloride.

Bentyl is a high milligram potency non-narcotic antispasmodic with two-fold musculotropic and neurotropic action. Effective therapeutically without atropine-like side actions in functional gastrointestinal disorders.

Bentyl is particularly suited for prolonged administration without habituation or increased tolerance.

Booth 24—Schering Corporation, Bloomfield, N. J.—Members of The Medical Society of New Jersey and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Included in this exhibit will be *Prantal Methylsulfate, Schering,* the first selective anticholinergic agent and *Dormison,* the new non-barbiturate hypnotic.

Schering representatives will be present to discuss with you these products as well as other products of our manufacture.

Booth 25—Ortho Pharmaceutical Corporation, Raritan, N. J.—You are cordially invited to visit our exhibit. The Ortho display will feature *Preceptin* Vaginal Gel, their new product for conception control designed for use without a vaginal diaphragm. *Preceptin* Vaginal Gel has achieved an outstanding record of clinical effectiveness and has been widely acclaimed by the medical profession. Your inquiries on *Preceptin* Vaginal Gel are invited.

Booth 26—U. S. Vitamin Corporation, New York, N. Y.—See and taste for yourself the new and different sodium-free salt substitute—*Co-Salt*—which actually tastes like salt, looks like salt and sprinkles like salt. . . a great boon to your patients on restricted sodium intake.

Exhibit also features original, complete lipotropic therapy—*Methischol*—the combination of five proven lipotropic agents: B_{12}, choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

Booth 27—Lederle Laboratories, New York, N. Y.—You are invited to visit our exhibit, where you will find representatives who are prepared to give you the latest information on Lederle products.

Booth 28—Buffington's Inc., Worcester, Mass.—Our exhibit will feature products of interest to all attending physicians. Representatives will be in attendance and will be prepared to offer valuable information concerning these newer therapeutic agents.

A cordial invitation is extended to all physicians in attendance to visit the Buffington booth.

Booth 29 — The Liebel-Flarsheim Company, Cincinnati, Ohio—You are cordially invited to visit our booth in which the latest diathermy and Bovie electrosurgical apparatus will be available for examination and demonstration. Capable representatives will be on hand at all times and we hope you will stop by so that we may become acquainted.

Booth 30—Nepera Chemical Co., Inc., Yonkers, N. Y.—Our display is devoted to two council-accepted products — *Mandelamine* for urinary antisepsis in such indications as cystitis, pyelitis and prostatitis; and *Neohetramine,* an antihistaminic agent which authorities declare to be notably low in side effects.

Booth 31—Bristol-Myers Company, New York, N. Y.—Members of the Society are cordially invited to visit our booth where representatives will be in attendance to answer any questions pertaining to *Bufferin, Ammens Powder, Sal Hepatica, Trushay* and other famous products on display.

Booth 32—Walker-Gordon Milk Co., Plainsboro, N. J.—The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, New Jersey, is the world's largest farm producing certified milk. It includes over 2400 acres of farm land and 2690 cows, bulls and growing heifers.

The farm was started in 1898 and has been producing a special high quality milk since that time. It is the only certified milk farm in the world with daily medical and veterinary supervision and a complete technical laboratory on the farm providing constant medical, laboratory and veterinary supervision 24 hours each day.

It is the home of the famous *Rotolactor,* the purpose of which is to make possible the production of a cleaner milk.

Walker-Gordon produces certified raw milk, certified pasteurized milk, homogenized Vitamin D and Acidophilus milk. It is distributed in the metropolitan areas of New York and Philadelphia and in the state of New Jersey by many leading milk dealers.

Booth 33—The Coca-Cola Company, Atlanta, Ga.—Ice-cold *Coca-Cola* served through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City and The Coca-Cola Company.

Booth 34—Camel Cigarettes, New York, N. Y.—*Camel* Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful *Camels.* This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

Booth 35—Parke, Davis & Company, Detroit, Mich.—Medical Service members of the Parke, Davis & Company staff will be in daily attendance at our commercial exhibit for consultation and discussion of the various products listed in our pharmaceutic, antibiotic, and biologic catalog. Important specialties, such as *Chloromycetin, S-R, S-R-D, Benadryl, Vitamins, Oxycel,* et cetera will be featured. You are most cordially invited to visit our exhibit with the assurance that your personal interest will indeed be very much appreciated.

Booth 36—White Laboratories, Inc., Kenilworth, N. J.—*Dienestrol*—the potent, orally effective synthetic estrogen, will be featured at the White Laboratories display. *Dienestrol* differs chemically from stilbestrol and other synthetic estrogens. It is unique in its action and is one of the best tolerated of all orally effective synthetic estrogens.

Booth 37—The Upjohn Company, Kalamazoo, Mich. — It is the sincere desire of The Upjohn Company to make some definite contribution to the success of the 1952 meeting. Stop by at our booth to relax and discuss topics of mutual interest.

Booth 38—Hanovia Chemical and Manufacturing Company, Newark, N. J.—Stop in and see Hanovia's new Short Wave Diathermy possessed of outstanding features. Acquaint yourself with the new Fluro Lamp (Wood's black light) a valuable aid in diagnostic work; general body and orificial quartz lamps, Sollux radiant heat lamps and Germicidal lamps will be on display. Competent and courteous representatives on hand to greet you.

Booth 39—Lanteen Medical Laboratories, Inc., Evanston, Ill.—You are invited to visit our booth. Representatives will be pleased to discuss with you a special offer available at this time.

Booth 40—Baby Service, Inc., Newark, N. J.

Booth 41—G. D. Searle & Co., Chicago, Ill.—You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be *Banthine,* the true anticholinergic drug for the treatment of peptic ulcers; *Dramamine,* for the prevention and active treatment of motion sickness; and *Alidase,* Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed.

Other time-proved products of Searle Research on which information may be obtained are *Searle Aminophyllin* in all dosage forms, *Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Paratrine,* and *Paratrine with Phenobarbital.*

Booth 42—Burroughs Wellcome & Co., Inc. (U.S.A.), Tuckahoe, N. Y.—*Acrosporin* brand Polymyxin B. Sulfate, a unique antibiotic, will be featured. *Acrosporin* is available in topical, parenteral

and oral preparations, and destroys Pseudomonas aeruginosa (B. pyocyaneus) and most other gram-negative bacilli.

Polysporin brand Polymyxin B-Bacitracin Ointment will also be displayed. *Polysporin* contains 10,000 units of *Acrosporin* (equivalent to 1 mg. of Polymyxin Standard) and 500 units of Bacitracin per gram. It eliminates both gram-negative and gram-positive organisms. *Polysporin* is especially effective against pyogenic skin infections, it rarely sensitizes and resistance rarely develops.

Booth 43—The S. E. Massengill Company, Bristol, Tenn.—You are invited to visit our booth, where several Specialty Products are on display. Your particular attention is called to *Obedrin Tablets* and *Semhyten Capsules. Obedrin Tablets* and the 60-10-70 Diet represent a combination that provides a practicable method of obesity control. *Semhyten Capsules* offer a broader approach to the treatment of essential hypertension and the product is effective as a prophylactic measure in combating malignant hypertension. Literature descriptive of these products is available and our representative will be glad to discuss them with you along with *Livitamin with Iron, Suspension Faoguan* and *Tablets Hisdrin.*

Booth 44—The Mennen Company, Newark, N. J.—We will exhibit *Baby Magic—Skin Care,* famous *Baby Oil* and *Baby Powder, Mennen Castile Baby Soap* and *Baby Cream;* also, our fungicidal foot powder, *Quinsana.*

Booth 45—Bilhuber-Knoll Corporation, Orange, N. J.—We present the latest developments in our medicinal chemicals and products:

Bromural—daytime sedative—mild hypnotic
Dilaudid—analgesic—cough sedative
Metrazol—central depression—senile confusion
Octin—migraine—spastic disorders
Theocalcin—cardiotonie—diuretic
Quadrinal—chronie asthma
Valoctin—sedo spasmolytic—dysmenorrhea

Your visits and discussions will be welcomed.

Booth 46—C. B. Fleet Company, Inc., Lynchburg, Va.—You are cordially invited to stop at our booth to see the exhibit of *Phospho-Soda (Fleet). Phospho-Soda (Fleet)* is a solution containing in each 100 c.c. sodium biphosphate 48 gm. and sodium phosphate 18 gm.

Phospho-Soda (Fleet), over the years, has won discriminating preference by thousands of physicians—because of its controlled action, its freedom from undesirable side effect, and its ease of administration.

There is only ONE *Phospho-Soda (Fleet).*

Safe and effective whenever laxation is needed.

Booth 47—Winthrop-Stearns, Inc., New York, N. Y.—You are invited to visit our booth where the following products will be featured: *Telepaque,* the new, highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear cut pictures of the gall bladder and, in a substantial number of cases, also permits visualization of the biliary ducts. *Neocurtasal* Iodized, trustworthy salt without sodium, with the addition of 0.01 per cent potassium iodide. *Milibis Suppositories,* new, highly effective specific against trichomonal, monilial, bacterial (nongonococcal) and mixed vaginitis. *Hidex,* high dextrin (83 per cent) mixed carbohydrate for the prevention and correction of colic and diarrhea in infant feeding, reinforced with Fergon (5 mg. per ounce), the best tolerated form of iron.

Booth 48—South Jersey Surgical Supply Co., Red Bank, N. J.—South Jersey Surgical Supply Company of Red Bank, New Jersey will appear for the fourth consecutive year at this annual meeting. They will feature the *Burdick FCC approved diathermy,* the *Burdick Direct-Writing Electrocardiograph,* and the *Allison's* newest *Honey Blonde Examining Suite.*

Booth 49—Carnation Company, Los Angeles, Calif.—You are cordially invited to visit our booth where you will see a series of translites on our canning and sterilization process. Carnation medical specialists will explain our sole processing and give you reasons why *Carnation Milk* deserves consideration as your first choice in infant feeding formulas.

Booth 50—Hoffmann-LaRoche, Inc., Nutley, N. J.—Two exceptionally interesting products will be featured at the Roche exhibit. One product is *Asterol,* a new antifungal drug which is of impressive value in ringworm of the scalp, athlete's foot and other fungus infections of the hair and skin. *Asterol* is available as an ointment, as a tincture, and in powder form. The other product is *Gantrisin,* the more soluble sulfonamide which has a wider antibacterial spectrum. *Gantrisin* is highly effective in the treatment of systemic and urinary tract infections.

Why not stop at the Roche booth where members of the field staff will be glad to discuss these and other Roche specialties with you?

Booth 51—Mead Johnson & Company, Evansville, Ind.—We will feature *Lactum* and *Dalactum,* convenient formulas of evaporated milk containing Dextri-Maltose; three water-soluble vitamin preparations, *Poly-Vi-Sol, Tri-Vi-Sol* and *Oc-Vi-Sol; Fer-In-Sol,* a palatable, highly concentrated solution of ferrous sulfate. Also *Mulcin,* a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four *Pablum* cereals, including barley and rice.

Representatives in attendance will be glad to furnish information regarding the above products.

Booth 52—Eli Lilly and Company, Indianapolis, Ind.—Your Lilly medical service representative cordially invites you to visit the Lilly exhibit. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

Booth 53—Cameron Surgical Specialty Company, New York, N. Y.—Cameron—"Instruments of Distinction."

Every doctor should visit the Cameron booth and at least *see* the diagnostic and operating instruments that are used by the leaders of the medical and surgical world.

Cameron instruments are different. They are precision-made to last a life time at a normal upkeep cost. Every doctor can afford at least *one* Cameron instrument.

"Keep your facility on a par with your ability."

See our small-electro-surgical unit for office surgical procedures. It will amaze you.

Booth 54—General Electric X-ray Corporation, Milwaukee, Wisc.

Booth 55—Ayerst, McKenna & Harrison, Ltd., New York, N. Y.—Physicians attending The Medical Society of New Jersey convention are cordially invited to visit the Ayerst booth where you will receive a warm welcome. Our representatives will be there to answer any inquiries relative to *Premarin, Antabuse, Testosterone* or other Ayerst specialties of interest to you.

Booth 56—Wyeth Incorporated, Philadelphia, Pa.—Wyeth Incorporated extends to you a cordial invitation to visit the Wyeth booth where trained representatives will be pleased to discuss and supply literature concerning many widely prescribed Wyeth ethical specialties. Featured in this exhibit will be *Wydase*—Wyeth's highly purified hyaluronidase, and the popular *Tubex* line — Wyeth's outstanding convenient form of injectable pharmaceutical preparations.

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THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS TO THE HOUSE OF DELEGATES

MAY 19, 20 and 21, 1952

PRESIDENT

Sigurd W. Johnsen, M.D., Passaic

The 186th Annual Meeting of The Medical Society of New Jersey brings to a close my term of office as your President. I am deeply grateful to all our members for a year which was outstanding for its cooperation and harmony.

To the Board of Trustees, to the Welfare Committee, its Subcommittees, and all the Advisory Committees, I express my sincere thanks for whole-hearted cooperation.

To our Executive Officer, Mr. Richard I. Nevin, for his splendid assistance and cooperation, I express heartfelt appreciation. This was Mr. Nevin's first year as our Executive Officer, and he proved himself a most valuable and able representative of The Medical Society of New Jersey. He has done an admirable job in coordinating and correlating our many activities, and he has been invaluable as an assistant to me and as a public relations spokesman.

To Mrs. Edith L. Madden and all the members of the staff of the Executive Offices, I am glad to acknowledge a debt of profound gratefulness for their dependability and willing help on every occasion. The work of the year has run smoothly and efficiently in large part because of the splendid assistance and support that they have given.

It would be impossible for me to enumerate, much less properly evaluate, the many projects and activities which are under way—some in early stages, others well advanced, and some ready for final adoption — all of which are the fruit of the efforts of our various committees and are of great importance to the welfare of our Society. To all of our members who have devoted and who are devoting their time and energy to these undertakings, I extend the thanks and the appreciation of our Society. I should like to make special mention of the generous and efficient work of the Welfare Committee, under the chairmanship of Dr. Samuel Blaugrund; of the activity and accomplishment of the Committee on the Medical-Dental School, under the leadership of Dr. Stuart Z. Hawkes; of the enterprise and attainment of the Public Relations Committee, under the leadership of its chairman, Dr. Joseph E. Mott; of the dependable and painstaking work done by the Committee on Legislation, under the chairmanship of Dr. C. Byron Blaisdell, ably assisted by Dr. Joseph F. Londrigan, Executive Secretary to the Committee. I think a special word of commendation is due to Dr. William G. Herrman and the members of the Committee on Physician Resources, whose work was this year brought to such satisfactory conclusion. Certainly, too, our appreciation and satisfaction must be expressed to Dr. Henry A. Davidson for his dependable and splendid service as Editor of The Journal.

No report of this kind can hope to do justice to all those who by their diligence and generosity have served the Society. Its work has gone forward and its interests have been advanced only because such a large number of our members have given generously of their time and ability. To all of them my profound and enduring thanks.

In the course of the year the Woman's Auxiliary established its own central office in our State Headquarters, with consequent increase of efficiency and accomplishment. I congratulate Mrs. McGlade and the other officers of the Auxiliary on their expanded program, and in the name of The Medical Society of New Jersey I wish to convey to them and to all the other members of the Auxiliary our praise and our gratitude.

Three new liaison committees have been organized this year with the approval of the Board of Trustees to further the objectives and interests of our Society insofar as they impinge upon the spheres of action of related organizations. The first of these was the Medical-Dental Liaison Committee which has operated for only a short time, but which has already cemented friendly relations between our two professions and has embarked upon a campaign of publicity and support for the projected establishment and operation of a grade A medical-dental school in the State of New Jersey. The Medical-Legal Liaison Committee was the second committee to be established, to be followed shortly by the organization of a Medical-Hospital Liaison Com-

mittee. These new committees, constituted at the highest level, bring together our professions in new and closer relationships which we hope will aid materially in the solution of many of our joint problems. We feel certain that they will lead to even greater cooperation and understanding in pursuit of our common aims, and that they will help in achieving greater effectiveness in our respective fields.

The Executive Committee of the Board of Trustees has met each month during the entire year, and to its members I wish to express thanks for their unselfish and generous help and cooperation. Their valuable advice and counsel have aided materially in expediting work of the Board of Trustees and have been invaluable to me in the discharge of my presidential duties.

To the members of the Board of Trustees and their chairman, Dr. David B. Allman, and to my fellow presidential officers, Drs. Murray, Decker and Lance, I pay an especial tribute of appreciation. They have generously contributed their time, their advice, and their efforts; and they have uncomplainingly accepted appointment on numerous committees. The junior officers have moreover carried on visitation programs to our component county societies which have been greatly instrumental in unifying the endeavors of our State Society.

Dr. Aldrich C. Crowe, our immediate past-president, has been characteristically unselfish and dependable in continuing his distinguished services to the Society. Continuation of the policies which he established have, I feel, resulted in accumulated benefits and advances.

In the death of Dr. Joseph G. Coleman, The Medical Society of New Jersey lost a member of the Board of Trustees who served long and faithfully. The example of Dr. Coleman's life as a practitioner and as a loyal and diligent member of The Medical Society of New Jersey has been an inspiration to all of us. We shall all miss him greatly.

In conclusion, I am happy to report that our Medical Society of New Jersey is in good health. With the active cooperation of the Trustees, the officers, and the general membership, it is functioning in a thoroughly democratic manner. With the kind of harmony and cooperation that now prevail, we can rest assured that our future will be secure so long as we all continue to carry on in the ideals and faith of those who have gone before us. This year of service in the office of President has been one of deep personal satisfaction to me. I shall cherish the memory of it all my life.

TREASURER

George J. Young, M.D., Morristown

As the fiscal year does not close until May 31, 1952, the annual report cannot be submitted at this time. An interim report will be presented to the House of Delegates on May 19, 1952, covering the accounts up to that time.

SECRETARY

Marcus H. Greifinger, M.D., Newark

All communications coming to the office of your Secretary have been promptly answered and a number of questionnaires from the A.M.A. and other state societies have been completed—questionnaires asking for information on the administration and set-up of our Society and committees.

By action of the Trustees, the 1952 *Official List* will not be published this spring as in the past. Publication is planned for the early fall. The *List* will contain an alphabetical roster of members as well as a listing by counties. Between the spring publication of the *Official List* and the early fall, there are nearly a thousand changes of address, addition of new and reinstated members, transfers in and out of the state, transfers within the state, and deaths. It is felt that the *List* should be as complete as possible, so for this reason, publication was postponed until fall.

At the close of March 1952, the membership record was as follows:

Active Members—Paid	4808	
Exempt	23	
Armed Service	109	4940
Associate Members		113
New and Reinstated Members		159
Members deceased—March '51-March '52		66
Transfers—March '51-March '52—		
Within State	18	
Out to Other States	17	
		35
Resignation		19
State Emeritus Members		81
State Honorary Members		6
County Emeritus Members—Honorary Members		100
County Courtesy Members		33
Delinquents (members in 1951 but not yet paid for 1952)		538

Each year approximately 10 per cent of the members allow their membership to lapse for a few months. They not only have their names removed from the mailing list of the Society but they jeopardize their insurance. It is suggested that county societies impress upon their members the necessity for keeping membership in good standing at all times. We know that the counties allow sufficient time between their billing and collecting of annual assessments, and that it is a laxity on the part of the individual member which places him on the delinquent list.

BOARD OF TRUSTEES

DAVID B. ALLMAN, M.D., Chairman, Atlantic City

In accordance with the procedure of other years, all the important actions taken by the members of the Board of Trustees at their meetings throughout the year have been from time to time reported to the general membership in The JOURNAL. This present report, therefore, mentions only the considerations and determinations which emerge as worthy of special comment.

DEATH OF DR. COLEMAN

The Trustees in common with all the other members of the State Society heard, with profound personal grief and a sense of great loss, the news of the death of Dr. Joseph G. Coleman on February 1, 1952. At the time of his passing Dr. Coleman was the senior member of the Board of Trustees, to which he had rendered uninterrupted and diligent service for a period of nine years.

WOMAN'S AUXILIARY CENTRAL OFFICE

Because of increased activity of the Auxiliary in conjunction with the organization and operation of its various programs, the Board approved the establishment of a central office for the Woman's Auxiliary at State Society Headquarters, Trenton, and the employment of a paid clerk to work under the direction of the President of the Auxiliary.

PUBLICITY RELEASES

It was agreed that all publicity releases by The Medical Society of New Jersey (except those made by the President, or Chairman of the Board of Trustees, and authorized releases by the Executive Officer) should be made by the Public Relations Committee directly or in consultation with the committee concerned.

SPECIAL LIAISON COMMITTEES

The Trustees approved the establishment of three special committees of liaison to coordinate the work of the Society with that of the agencies of liaison for the pursuit and attainment of common objectives. Accordingly there were established a Medical-Dental Liaison Committee, with the New Jersey State Dental Society; a Medical-Legal Liaison Committee, with the New Jersey State Bar Association; and a Medical-Hospital Liaison Committee, with the New Jersey Hospital Association.

COMMITTEE TO EVALUATE LIAISON

The Board authorized a special committee whose function will be to give extensive study to the Medical Society's liaison with all outside organizations and agencies through its various committees already established. The President-Elect was named Chairman of this Committee, and the first and second Vice-Presidents were designated as regular members.

COOPERATION FOR MEDICAL-DENTAL SCHOOL

The Trustees approved a policy of close cooperation among the Committee on the Medical School, the Public Relations Committee, and the Subcommittee on Legislation to develop a three point program of concentrated effort in support of the proposal for the establishment of a medical-dental school in New Jersey. It also recorded itself as strongly reaffirming the definite need for a grade A medi-

cal-dental school in New Jersey and as united in the determination not to take a stand as favoring one site over another.

COMMITTEE ON THE NEW JERSEY PLAN

The Board dismissed with an expression of appreciation for the work already accomplished the Committee on Implementation of the New Jersey Plan. It subsequently approved the appointment of a new committee to be composed of the Society's A.M.A. Delegates, whose function will be further to study and evaluate the New Jersey Plan.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

The Board of Trustees on April 6 approved the following amendments to the Constitution and By-Laws and recommend their adoption by the House of Delegates:

ARTICLE VI—BOARD OF TRUSTEES

The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district (delete "who shall be elected as follows:") substitute: and who shall each be elected for a term of three years, such term to commence upon expiration of the term of the then incumbent.

From and after May .., 1953, any member may be elected a trustee for a maximum of three full terms, provided, however, that if the first two elected terms are successive, there shall be a lapse of one year between expiration of the second and commencement of the third term. The term of any trustee commencing prior to May .., 1953, shall not be included in the limitation of three elected terms.

CHAPTER I—MEMBERSHIP

Section 2—Official List of Members

(a)—(Delete present paragraph (a);) substitute the following:

(a)—Five days before the first of March, the Treasurer of each component society shall forward to the Treasurer of this Society, a complete list, in duplicate, of all paid up members in good standing with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the official list from the lists so received by the Treasurer and such official list as published shall be prima facie evidence of the right of members to register at the annual meeting.

(d)—(Delete present paragraph (d);) substitute the following:

(d)—Immediately after December 31 of each year the Secretary of the Medical Society shall notify each county society of the number of delegates to which it is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date.

CHAPTER IX—FINANCE

Section 2—General Fund

(a)—(Delete present paragraph (a);) substitute the following:

(a)—Annual Assessment of Members. On the first day of January in each year there shall be levied on each component society a per capita assessment on the membership of such component society, as hereinafter set forth (par. b), to be paid to the Treasurer of The Medical Society of New Jersey not later than five days before the first day of March, together with a list of the members for whom such payment is made. A similar per capita assessment shall be paid in the same manner immediately upon the admission or reinstatement of any member except that for a new member admitted after October 1 of any calendar year, one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as a subscriber to and entitled to receive the JOURNAL.

No assessment shall be levied against any member in good standing if (a) he shall have attained the age of 70 years, or (b) he is serving with the armed forces of the United States, or (c) he is exempted by the component society from the payment of annual dues

for financial reasons, such exemption to be reviewed annually by The Medical Society of New Jersey, or (d) he is a member emeritus.

If a member has not paid his dues by June 1, his name shall be dropped from the membership rolls.

Proposed Deletions From By-Laws

For the information of members, section 4 of Chapter X of the By-Laws is here reproduced in full:

SECTION 4—APPEALS

Any physician who may feel aggrieved by the action of a component society in refusing him membership, or any member of a component society who has been suspended or expelled, shall have the right of appeal through his District Councilor to the Judicial Council. The powers of the Judicial Council and its method of procedure are defined in Chapter VII of these By-Laws.

In this connection, our counsel, Mr. Gerald O'Mara, has reported: "There is a conflict between Chapter VII, Section 10, and Chapter X, Section 4. The latter appends an additional procedure which is not provided for in Chapter VII. That procedure is that the appellant must proceed *through his district councilor.* I do not think that is the intention of the amended By-Laws governing appeals. To that extent, there is a conflict. I would recommend that Section 4 of Chapter X be excluded from the By-Laws since it is merely repetitive and since Chapter VII is intended fully to outline the judicial process with the Society."

The Society's counsel, Mr. Gerald O'Mara, has proposed that Chapter XIV of the By-Laws be deleted. The chapter is quoted in full for the information of the members:

CHAPTER XIV — CONFERRING THE DEGREE OF DOCTOR OF MEDICINE

Candidates for the degree of Medicinae Doctor may apply to any component society of this state, and shall be admitted to examination under the following rules and regulations:

First. Each component society shall appoint annually, or *pro re nata,* a committee of not less than five members, who shall conduct the examinations.

Second. All examinations shall be in the presence of The Medical Society of New Jersey at a regular meeting; and no candidate shall be examined until he has given satisfactory evidence of having reached the age of twenty-one years, is of good moral character, that his preliminary education has been such as to qualify him for the study and practice of medicine, and has pursued his medical studies in some medical college whose requirements do not fall below the minimum standard of the Association of American Medical Colleges.

Third. The examination shall extend to all of the branches taught in the medical schools recognized as aforesaid; and the candidate shall then be balloted for by The Medical Society of New Jersey. If he shall receive the approving votes of two-thirds of all the members present, the presiding officer shall give a certificate to that effect to the candidate.

Fourth. The certificate may be presented at the next or any subsequent regular meeting of The Medical Society of New Jersey, not extending beyond the period of three years, with a written thesis upon some medical subject; and if, upon a ballot, he shall be approved by a majority of the members present, the candidate, upon the payment of fifteen dollars, shall be entitled to receive a diploma in the following form:

This will certify that we censors of the District Medical Society for the County of appointed by The Medical Society of New Jersey, have this day carefully and impartially examined of county of state of and being well satisfied with his attainments in the various branches of Medical and Surgical Science and of his moral character do recommend him to the president of The Medical Society of New Jersey as a proper person to receive a license to practice physic and surgery throughout the state of New Jersey.

In reviewing this chapter, our counsel states: "Although the amended Charter of 1864 grants the Society the right to confer the *degree* of Doctor of Medicine, and though Chapter XIV refers to the conferring of a *degree,* nevertheless, the form of certificate provided to be issued under Chapter XIV is in effect a recommendation to the President of the Medical Society that the applicant should receive a *license* to practice medicine.

"The Act of 1894, as amended, setting up the State Board of Medical Examiners grants to that Board an *exclusive* right to grant a license to an applicant. Title 45:9-6 reads as follows: '*All persons* commencing the practice of medicine or surgery in this state shall apply to the Board for a license so to do.'

"In my opinion, should the formula provided by Chapter XIV of the By-Laws be followed, the applicant would, nevertheless have to proceed in accordance with the provisions governing the State Board of Medical Examiners.

"My conclusion is that the Act of 1894 has repealed by implication, if not expressly, the authority conferred upon the Society by the Reorganization Act of 1864. I am certain that if the matter were tested that the court would hold the Society is not empowered to license an applicant to practice. Whether it would be empowered to grant a *degree* is aca-

demic since all applicants now must possess degrees before applying. I would suggest, therefore, that the quoted language be omitted when the constitution and by-laws is reprinted. I think serious consideration should be given by the Trustees to the question of exscinding Chapter XIV from the By-Laws in its entirety. Certainly, it is an archaic form and will never be invoked by the Society in this day and age."

JUDICIAL COUNCIL

VINCENT P. BUTLER, M.D., Chairman, Jersey City

This is the first report since the change in the Constitution making the Judicial Council the Judiciary Body of The Medical Society of New Jersey. The primary functions of the Judicial Council now are: to consider and rule on all questions of an ethical nature arising within The Medical Society of New Jersey; to receive and act upon all appeals by members of the society and public from decisions of county medical society judicial bodies; and to receive complaints and accusations from any source concerning the professional conduct or ethical deportment of members of The Medical Society of New Jersey.

On only a few occasions has the Judicial Council been called upon to consider matters relating to the ethical conduct of the members, and in none of these instances was there any serious violation of ethics. Rather it was a lack of understanding of the principles set down to guide correct professional conduct that was generally involved. In this connection it would seem desirable that each physician acquaint himself with the *Principles of Medical Ethics* of the American Medical Association.

When the formation of a Grievance Committee within The Medical Society of New Jersey was being considered it was feared by some that there would be a deluge of complaints from emotionally disturbed individuals. This fear has not been substantiated. For, while there was an increasingly large number of complaints following the initial announcement of the committee's formation, the number has been gradually decreasing. Many of the complaints are well-founded; many are not. Some well-meaning patients have felt they were badly treated, and, while they sought no punitive action against the physician, have felt his conduct should not go unnoticed. On the other hand there has been a sizeable number of complaints which proved to be unfounded. All complaints received in writing have been looked into. If the complaint comes first to the Judicial Council of the State Society it is assigned to the District Council, which is composed of two members from each society in the district. During the past year (while the District Councils were being formed) most of the function of that body has fallen to the District Councillor. District Councils have been established and are now ready to operate. A settlement of the grievance by arbitration to the satisfaction of all concerned is here attempted. If settlement is successful at the level of the District Council, the Judicial Council is notified and the matter closed. If not so settled, the matter is referred to the county medical society judicial body.

In a complaint lodged with the county society, its own judicial committee will have discretion as to whether it will hear the case or refer it to the Judicial Council. This decision will be indicated on the report blank which each county society has been furnished. When a complaint is disposed of by the county judicial committee, the decision is filed on a blank provided for that purpose by the Judicial Council.

The judicial bodies functioning in the several county societies have been able to settle most of the grievances to the satisfaction of those concerned. This is evidenced by the fact that but four appeals from their decisions have been taken to the Judicial Council of The Medical Society of New Jersey this year.

It is our experience that the commonest complaint concerns fees or the misunderstanding of what was to be expected in the treatment of a patient. Where possible it would be wise to have a clear understanding between the physician and patient regarding these considerations before treatment is begun.

There has been generally a favorable reaction to the Medical Society's efforts to assure the public that we do not condone professional misconduct and that we are no more

in sympathy with those members who ignore their responsibilities than are those who have been exploited. While the grievance committees are acting primarily in the public interest, they also serve the purpose of keeping the doctor's record clear among his colleagues when he has been unjustly accused.

As chairman of the Judicial Council I should like to thank the other members who have served with me; Drs. Featherston, Weber, Ulmer, and Mann. They have rendered fine service during the past year. Theirs has been no small task, but their willingness to undertake whatever confronted them and their painstaking judgment in achieving the solution of many knotty problems have won my admiration and thanks and, I am sure, the admiration and thanks of every member of The Medical Society of New Jersey.

It is with regret that we learned of the recent resignation of the senior member of the Judicial Council, Dr. Chester I. Ulmer. His service has been long and productive of much that is good. The high ideals of medicine which he possesses together with his incisive judgment have added greatly to our deliberations during his tenure of office. His presence will be greatly missed.

FIRST COUNCILOR DISTRICT

Union, Warren, Morris and Essex Counties

FRANCIS C. WEBER, M.D., Newark

At the local level there were no matters for adjudication. Several matters had to be brought to the attention of the State Judicial Council. These were all reported, acted upon and disposed of. All State meetings of the council were attended by me. These will be reviewed by Dr. Butler, Chairman, when he reports for the Judicial Council. To enumerate them here would be repetitious.

SECOND COUNCILOR DISTRICT

Sussex, Bergen, Hudson and Passaic Counties

VINCENT P. BUTLER, M.D., Jersey City

There have been no matters involving the rights of members either in relation to each other or to the component societies brought to the attention of the Councilor of the Second Judicial District this year.

Each of the societies comprising the District have been most cooperative and have already in operation or in process of formation judicial bodies which will concern themselves with the professional conduct and ethical deportment of their members.

THIRD COUNCILOR DISTRICT

Mercer, Middlesex, Somerset and Hunterdon Counties

J. J. MANN, M.D., Perth Amboy

As the representative for the Third Judicial Council, I attended all the meetings called by the chairman, Dr. Butler. No cases called to the attention of the Council involved any members of the society practicing in the four counties under this jurisdiction.

FOURTH COUNCILOR DISTRICT

Camden, Burlington, Ocean and Monmouth Counties

D. F. FEATHERSTON, M.D., Asbury Park

Several matters pertaining to the fourth Judicial Council were handled during the year as part of the routine business of the Judicial Council, and will be included in its report.

FIFTH COUNCILOR DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

CHESTER I. ULMER, M.D., Gibbstown

No matters of an ethical or judicial character were brought to the attention of the Councilor of this district during the year.

It would appear that the county societies in this district are functioning well and with harmony.

EXECUTIVE OFFICER

Richard I. Nevin, Trenton

Time spent in activities that are interesting and absorbingly worthwhile is always swift in its flight. Consequently, the year which I have just completed as Executive Officer of The Medical Society of New Jersey—my first full year in that capacity—has passed with almost incredible speed. This has been a year of initiation and discovery for me, in the course of which I have grown to feel progressively at home in the large family of the Society, and increasingly proud and happy to be part of it.

Were I asked to specify what I consider the single best asset of the Society and that which most favorably guarantees its continuing high place in the affection and esteem of the public, I would unhesitantly answer "the good will of our members". Perhaps some might think that professional competence should be cited as of prime importance, but it is my strong conviction that in this regard, like faith without good works, professional competence without good will is vain. That there is abundant good will enriching the service of medicine was manifested to me on every hand. It shone forth in the spirit of earnestness and self-sacrifice which characterized the officers and members of the Board of Trustees. It was reflected in their efforts and attainments, as it was in the wholesome and ungrudging service of the members of all the various committees of the State Society. It was evident throughout the entire year in the cooperation and loyalty of the members of the executive staff. I found it again in the cordial and eager cooperation of all our component county societies and in the constructive and graciously effective undertakings of the Woman's Auxiliary. This same spirit has fostered and advanced our association with other groups and agencies, such as those represented in the creation of our new committees of liaison with the State Dental, Bar, and Hospital Associations. It inspired the widespread enthusiasm that made possible the adoption of mechanisms at county level for 'round-the-clock emergency service and for the achievement of better public relations in all phases of contact and activity. . . Much has been accomplished this year through good will effectualized through the medium of honest and unselfish effort. Following this formula, we can achieve still more.

The threats to medicine although momentarily less clamorous are still sinisterly vigorous. There should be solace and encouragement for us, however, in the realization that no assault from without can avail against the abiding vitality of combined integrity, intelligence, and good will within. Enlightened and high-souled competence has little to fear from the threats of hostile mediocrity. It is our task to preserve the strength and integrity we have, and to add to it by the merits of our constructive efforts through each succeeding day. We of medicine must not be content to fight a defensive battle. As against disease and death, our strategy is attack—attack against the very strongholds of our opposition—by a forthright avowal of and an uncompromising devotion to the ideals and principles of community life and service which have made, and which alone can preserve, medicine as the most exalted and beloved of professions.

Because of these goals and because of this spirit, it is a great satisfaction to be identified with The Medical Society of New Jersey. These are times which challenge men and women of vision and leadership—against a background of dark failure—to point out the bright road to survival and accomplishment. No compromise is possible; with us, none is contemplated. Working together, as in the past, we can and will do the job.

NOMINATIONS FOR EMERITUS MEMBERSHIP

The following nominations for election to Emeritus Membership at the 1952 Annual Meeting have been received from the various county medical societies:

Atlantic County—Dr. C. Coulter Charlton, Absecon; age 65; retired because of age; member in good standing since 1912.

Bergen County—Dr. David Corn, Teaneck; age 70; retired because of ill health; member in good standing since 1908; also nominated for A.M.A. Associate Fellowship.

Dr. George M. Levitas, Westwood; age 70; retired because of ill health; member in good standing since 1906; also nominated for A.M.A. Associate Fellowship.

Camden County—Dr. Ernest W. Clark, Haddon Heights; age 55; retired because of ill health; member in good standing since 1924; also nominated for A.M.A. Associate Fellowship.

Essex County—Dr. Chester R. Brown, Arlington; age 69; retired because of ill health; member in good standing since 1910; also nominated for A.M.A. Associate Fellowship.

Dr. Charles V. Craster, Newark; age 80; retired because of age; member in good standing since before 1930.

Dr. James J. Edelen, East Orange; age 64; retired because of ill health; member in good standing since 1917; also nominated for A.M.A. Associate Fellowship.

Dr. Harry B. Epstein, East Orange; age 80; retired because of age; member in good standing since 1898; also nominated for A.M.A. Associate Fellowship.

Dr. Julius Levy, East Orange; age 71; retired because of age; member in good standing since 1905; also nominated for A.M.A. Associate Fellowship.

Dr. Browne Morgan, Bloomfield; age 78; retired because of age; member in good standing since 1916; also nominated for A.M.A. Associate Fellowship.

Dr. William Petry, Newark; age 80; retired because of age; member in good standing since before 1930.

Dr. Frederick G. Shaul, Bloomfield; age 74; retired because of age; member in good standing since 1902; also nominated for A.M.A. Associate Fellowship.

Dr. Harold A. Tarbell, Newark; age 74; retired because of age; member in good standing since before 1930.

Hudson County—Dr. Charles H. Finke, Jersey City; age 80; retired because of age; member in good standing since 1909; also nominated for A.M.A. Associate Fellowship.

Dr. George W. Muttart, Jersey City; age 86; retired because of age; member in good standing since 1902; also nominated for A.M.A. Associate Fellowship.

Dr. Alfred A. Mutter, Arlington; age 68; retired because of ill health; member in good standing since 1919; also nominated for A.M.A. Associate Fellowship.

Mercer County—Dr. John H. McCullough, Trenton; age 81; retired because of ill health; member in good standing since before 1930; also nominated for A.M.A. Associate Fellowship.

Middlesex County—Dr. John F. Anderson, New Brunswick; age 81; retired because of age; member in good standing since before 1930; also nominated for A.M.A. Associate Fellowship.

Dr. Chester T. Brown, Highland Park; age 70; retired because of age; member in good standing since before 1930; also nominated for A.M.A. Associate Fellowship.

Dr. Charles I. Silk, Perth Amboy; age 78; retired because of age; member in good standing since before 1930; also nominated for A.M.A. Associate Fellowship.

Ocean County—Dr. Frank Lehmacher, Lakewood; age 74; retired because of ill health; member in good standing since 1932; also nominated for A.M.A. Associate Fellowship.

Somerset County—Dr. Lancelot Ely, Toms River; age 77; retired because of age; member in good standing since 1907; also nominated for A.M.A. Associate Fellowship.

Dr. Frank L. Field, Far Hills; age 82; retired because of age; member in good standing since 1897; also nominated for A.M.A. Associate Fellowship.

Union County—Dr. Fred W. Sell, Rahway; age 82; retired because of age; member in good standing since 1898.

Dr. Charles B. Lufburrow, Plainfield; age 80; retired because of age; member in good standing since 1909.

Dr. Grace Holmes, Elizabeth; age 77; retired because of age; member in good standing since 1918.

Dr. Ida H. Frohwein, Elizabeth; age 73; retired because of age; member in good standing since 1924.

STANDING COMMITTEES

FINANCE AND BUDGET

David B. Allman, M.D., Chairman, Atlantic City

The year now drawing to its close has been one of sustainedly lively activity for the Society. The many committees have functioned with vitality and efficiency — always safely within the limits of their budgetary allotments.

Any report of the Committee on Finance and Budget prepared for publication in advance of the convention must always be tentative and general in character. Only after completion of the fiscal year does it become possible to speak in precise and accurate terms of the year's finances.

From our point of view this has been a sound and satisfactory year, as we expect to demonstrate when the final budget is submitted for approval at the annual meeting of the House of Delegates on May 19, 1952.

HONORARY MEMBERSHIP

Royal A. Schaaf, M.D., Chairman, Newark

No items have been referred to this Committee for its consideration.

MEDICAL EDUCATION

Francis M. Clarke, M.D., Chairman, New Brunswick

During the past year the attention of the Committee on Medical Education has been divided between promoting and advising in the conduct of graduate courses for practitioners in several counties and in attempting to obtain funds for the reorganization of the work and function of the Committee as outlined in the body of this report. Short graduate courses have been given (with the advice of Dr. Purcell of Trenton) in Cumberland, Morris and Mercer counties which were attended by 89 physicians. These courses consisted of a series of five to ten lectures on subjects of clinical importance and interest, and as heretofore, were given under the auspices and management of Rutgers University. The Rutgers Plan, at Cooper Hospital under the direction of Dr. Decker, has been inactive during the past year pending further studies and reorganization of this phase of the work of the Committee. Since the preparation of the following report of the work and purposes of the Committee, the work of the Subcommittee on a Medical School under Dr. Stuart Hawkes has been transferred to a special committee organized under the direction of the Welfare Committee under the chairmanship of Dr. Hawkes. The reference below to the activities of this Subcommittee is therefore pertinent until the creation of this special committee about one year ago.

The Chairman of the Medical Education Committee has been interested particularly in obtaining a grant from private sources for the organization and furtherance of the work of the Committee as outlined below. While it is impossible at this time to report an actual accomplishment of this objective due to the complexity of the problem itself and of the times in which we live, the Chairman is presently engaged in some consultations for which he has great hopes of success. The following report of the work and purposes of the Committee was prepared in anticipation of these efforts, and is being published for the interest and information of the members of the Society, and in the hope that it may arouse an active interest on the part of any others to

whose attention it may come. The Committee invites suggestions on the furtherance of this work.

The Medical Education Committee is a standing committee of The Medical Society of New Jersey which was established about thirty years ago. Its function is to provide a continuous program of graduate education for the members of the Society, within the resources of the Society. It advises upon and correlates all the graduate activities of the special committees, in cooperation with established educational institutions. It has been designated as the Advisory Committee to Rutgers University in medical matters, although it has never functioned formally in that capacity. It is presently composed of Dr. Henry Decker of Camden, Dr. Samuel A. Cosgrove of Jersey City, Dr. Ernest Purcell of Trenton, Dr. Stuart Z. Hawkes of Newark, and Dr. F. M. Clarke of New Brunswick. In 1946 it was reorganized into its present form at the suggestion of the then Chairman, Dr. Decker, who has continued to serve as Chairman until his recent resignation, following his election as a Vice-President of the Society. Following the resignation of Dr. Decker, Dr. Clarke was appointed as Chairman of the Committee. Each of the five members of the Society acts as Chairman of a Subcommittee of the Committee as a whole, to which certain specific duties are assigned. One subcommittee, under the Chairmanship of Dr. Decker, deals with the operation and extension of the Rutgers Plan at the Cooper Hospital in Camden. A Subcommittee, under the Chairmanship of Dr. Cosgrove, deals with the training of residents and interns, and two other Subcommittees, under the Chairmanship of Dr. Purcell and Dr. Clarke, deal with the subject of graduate lecture courses, as they are now given and as they may be expanded; and Dr. Hawkes serves as Chairman of a Subcommittee, begun in April 1948, which has dealt with the development of a medical school in New Jersey. The Rutgers Plan, operating at the Cooper Hospital in Camden, is designed especially for the progressive education of the general practitioner in the various specialties, or divisions, of clinical medicine. This was begun in October 1946. Essentially, it consists of the attendance of the practitioners at a hospital clinic for one session weekly for three years. During this period, the practitioner rotates through all of the clinics in the Out-Patient Department. Such training rounds out his education in the care of the ambulatory patient, and is of value to the hospital staff and to the patient. As a complement to the operation of this plan, a reorganization of the hospital staff on a division basis was necessary. Scientific meetings in each division were required. This was gratifying, because it developed that various staff members had scientific teaching abilities that would otherwise have been lost".* Dr. Decker is of the opinion that the entire plan has been of great benefit to the hospital staff. Following the completion of the three-year term of rotating service through the dispensaries of the Cooper Hospital, the practitioner receives a certificate of completion of the course from Rutgers University. Dr. Cosgrove for many years has been Director of the Margaret Hague Maternity Hospital, one of the largest maternity services in the country. This is affiliated with Columbia University, in which institution Dr. Cosgrove is Clinical Professor of Obstetrics, and on the Service are a large number of interns and residents, graduate students and observers. This Service is so large and is so ably directed and conducted by Dr. Cosgrove and his Staff, that it has become an important center for the teaching of clinical obstetrics, and Columbia University has been glad to include it as a valuable member of its teaching facilities. As matters now stand in this state, the presence of interns and residents in each hospital is the concern of the individual hospital, and as a result, the state is almost without intern service in its hospitals. The intern's period of service is usually one to two years. This does not fit him for practice in advanced fields of medicine, or of the specialties. It is essentially a period of laying the groundwork for further advancement. Formerly, almost all hospitals in the state were amply supplied with interns of good quality. With the advancement of medicine in recent years, and the lack of adequate academic affiliation of hospitals in New Jersey, and of formal educational programs, young men seek services in established medical centers elsewhere, with the result that such centers have become greatly overstaffed, and the actual training received by interns is often more imaginary than real. It *is* possible to care for patients adequately without interns; but the constant stimulus of young and eager men is of great benefit to the patient, to the hospital, to the staff, and ultimately to the community and to the state as a whole. The quality of the medical profession in any state is greatly influenced by the quality of the men serving as interns in its hospitals. At present, a very large proportion of the interns of the hospitals of New Jersey are graduates of foreign schools. A large number of these men will ultimately settle in the state, with very obvious effect upon the nature and

* From a report prepared by Dr. Decker and published in The Journal in April 1948.

quality of medical practice. This is a matter of the greatest importance to the future welfare of New Jersey. There are many intangibles in the personalities of outstanding physicians, and these qualities are not measurable in terms of technical training, important as such training is. There is one county in this state which especially prides itself upon the excellent quality of its medical profession, and they ascribe this excellence, in large measure, to a rule of seventy-five years' standing, which requires that all candidates for appointment as interns in the oldest and largest hospital in that county shall be interviewed personally by a committee of its Board of Managers. Practice of medicine is not merely the business of treating the sick, but it tends to become so without the stimulus of academic activity and association, and it requires an unusually strong mind to maintain the proper standards in the absence of such association. In the past generation, there has been a general trend by the best hospitals toward affiliation with established educational institutions, and our own plans for the hospitals in the state look definitely towards such moves. We also look forward to the ultimate establishment of a medical school in this state, and anticipate that our own program, as developed, will be merged with the program of this school and will continue to operate as an extension activity of the medical school. During recent years there has developed a tremendous interest in advanced education in general medicine and in its specialties, and educational programs have developed rapidly and extensively in almost every state in the Union. This has been accentuated by the development of Examining Boards for certification in the specialties. Most of these Boards admit candidates for examination only after periods of preparation which have seemed to them proper; and more and more, these periods of preparation have centered around formal educational programs which have, up to now, been offered only in established centers of medical education. This has led to tremendous overcrowding of these centers with resulting inadequate opportunities for practical instruction of the individual student. Institutions, which formerly had gotten along well with 15 or 20 residents, have had as many as 125 or even 150 in recent years. This has actually necessitated the organization of these large numbers of residents into classes to be taken around for didactic, bedside, and laboratory instruction, whereas formerly the contact of the resident with the patient and with the teaching staff was much more intimate and much more effective. Such instruction constitutes far more than substance, and the resident, on completing his term of such training, finds himself more poorly prepared for serious practice than he had had reason to expect. Our Committee wishes to explore this problem in association with the various Examining Boards, and to look into the possibility of the organization of the facilities of many fine hospitals and of many able physicians and surgeons of this state into programs of graduate education, which will be recognized for their true worth by all authorities. Such a program will require an association with established educational institutions to give it stability and academic recognition. At present, all resident and intern training is accomplished by individual hospitals at great individual effort. One hospital actually maintains a lecture and demonstration staff at its own expense. At least two other hospitals delegate residents to basic graduate work elsewhere in the specialty fields, and then have them return to their institutions for service in that specialty for one or two years. This is an expensive and impractical method, but is thought to be necessary to these institutions, and is maintained by them in the public interest, to train young men of high quality to assume future responsible practice in their respective communities. Training in the basic science is generally required by all authoritative agencies, such as the Council of Medical Education of the American Medical Association, the American College of Surgeons, and the specialty Boards, as an essential part of approved advanced or resident training programs. Our Committee looks forward to a plan of regional training, whereby several hospitals in various parts of the state can pool their efforts in those parts of the program which cannot be accomplished within their own staff. This will require the services of a professional medical educator to arrange and coordinate the work among the various groups of several hospitals, in association with Rutgers University. It is our hope that eventually some recognition of such well organized and well coordinated work will be made by the specialty Examining Boards, and it is our hope that eventually all properly equipped and organized hospitals within the state will participate in this program on a regional and state-wide basis. We also hope to work out some system of academic recognition or credit for such work, as it is a basic trait of human nature to desire some outward reward for effort. Other advantages would follow such an arrangement, such as a better coordination of hospital staff meetings, a better organized presentation of scientific material from the hospitals, the elimination of duplication of presentations of material, and a possible lessen-

ing of the number of minor meetings which members of the various hospital staffs are now expected to attend. There is widespread general complaint as to this last, as present demands place impossible burdens of attendance upon many of our most active and able men. Much of value to hospitals, to the medical profession, and to the state as a whole, may well be accomplished in this field of coordination of the scientific and teaching activities of hospitals on some sort of regional basis.

The courses given under the auspices of the Subcommittees on Short Courses and the Planned Subject Courses have been given through the Extension Division of Rutgers University, under the direction of Professors Norman Miller, Maurice A. Chaffee and Roderick Light. Following consultation with local physicians and with the Educational Committees of the county societies, these Subcommittees have suggested courses and lectures to the members of the Extension Division of Rutgers University, who have then procured the services of the designated lecturers, and have arranged the mechanics of the presentation. These courses have been given at the most convenient hours of the day or evening in various centers. The Society and the profession in general are tremendously indebted to Professors Miller, Chaffee and Light for their very great assistance, without which it would have been impossible to carry on this work. The selection and the obtaining of a proper auditorium, the arrangement of lighting, the arrangement of transportation for the lecturer and demonstrator, the procurement and setting up of microscopes and other equipment, the mechanics of enrollment and the collection of fees, especially those paid through the Veterans Administration, and the disbursement of monies, all have presented problems far beyond the capacities of the various committee chairmen busily engaged in their own necessary daily activities. These duties have at times undoubtedly placed a heavy burden upon Dr. Chaffee, Dr. Light and their staff who are also constantly engaged in the other Extension activities of the University. In the past year, Mr. Harry Layton has undertaken this work at the direction of Dr. Chaffee and Dr. Light. With the development of the program which the Committee foresees, it will be quite impossible for the University with its present staff properly to care for this work, which will require the services of a full time professional medical educator and administrator. The general program of the Medical Education Committee and the scope of its work as developed in the past years, and especially as it should develop in the future, is now far beyond the capacities of the members of the Committee operating on a part time voluntary basis.

Each of the county societies has always had a Committee on Postgraduate Education. Their work has been the backbone of the presentation of advances in clinical medicine to the profession as a whole through the years. However, necessarily, their work has lacked state-wide coordination, and this fact, among others, suggested the formation of the State Committee on Postgraduate Education, whose function was, in some measure, to coordinate the various educational activities of these 21 county societies. The State Committee now finds itself in the position of needing further coordination, organization, and administration of its own current operations, and especially of the greatly expanded program of graduate education which it envisions.

Dr. Purcell, the Chairman of the Subcommittee on Short Courses, has personally, and with great success, promoted and administered these courses for many years, especially in Mercer and in the counties adjoining. These short courses have usually been of eight weeks' duration and have covered a wide variety of subjects, usually of a clinical nature, and often consist of a series of lectures on both related and unrelated clinical subjects. They have been of great value in introducing different points of view and recent advances, to aid busy practitioners in keeping abreast of current practice and thought. The Planned Subject Courses, in recent years under the direction of Dr. Clarke, have been of 16 or 32 weeks' duration, corresponding to the University semester, and have been concerned with basic subjects for the entire semester, such as pathology, internal medicine, surgical pathology, gynecologic pathology, physiology and physiologic chemistry. During the year 1948-49, seven courses in these two groups were given in four counties to 217 student-physicians, and during 1949-50, the Extension Division of Rutgers University operated, for these two Subcommittees, four courses in four counties with a total enrollment of 1360. During the period of 1946-47 through the first half of 1951, a total of 1247 physicians have registered in these two groups of courses given through the Extension Division of Rutgers University. These have been offered to any physician wishing to attend, and have been given in eleven counties of the state. They have given busy practitioners graduate opportunities in their own communities, or in communities easily accessible to them, at times of the day or week most convenient to themselves and without the necessity of disrupting their practice, as would usually have been necessary if the same work

had been taken outside the state. This is progressive adult education in the science and art of medicine. Our state is ideally situated for such activities. It is geographically small, densely populated, and lies between two great medical centers. All parts of the state are easily reached from within or without. A graduate of twenty years' standing would require as long reasonably to acquaint himself with advances in medicine which have occurred since his graduation, as it took him to graduate originally. It is not possible, nor is it necessary, for all to know all; but all should keep abreast of the field relating to their own practice and as many of the others as is feasible. Graduate courses are not the only means by which this may be done, but such courses are most helpful.

Many states have most elaborate programs in collaboration with their established educational institutions, and nearly all states have programs of greater or lesser scope. Many are of great interest and worth, and merit closer study by our committee and by our associates at Rutgers than our facilities allow. Kansas has a very fine program which we would like to know more about, but cannot learn about because of lack of personnel and facilities. Michigan has a great program in connection with the State University at Ann Arbor. This includes extension work in regional communities throughout the state, and intensive one, two, or three day meetings of suitable groups, held in a building especially planned for such work at Ann Arbor. The Medical Society of Pennsylvania has a budget of $25,000 for its graduate education program, and a discussion of graduate extension work and of graduate medical education in Texas by its various medical institutions recently appeared in the popular press. Such programs need the services of an experienced professional educator and administrator, and an adequate full time secretarial staff who will give it constant attention. Such an administrator will consult with all interested groups, especially with the committees of the county societies as to their needs and wishes, and will constantly promote suitable programs in association with such established groups and committees. He will be of great assistance to local academies and medical associations in arranging and coordinating educational activities, and in obtaining the services of suitable speakers, either from within or without the state. There are a large number of gifted and able teachers throughout New Jersey whose services and talents are presently little used in these fields which under such a plan will be widely available. Such an administrator will be in communication with other State Societies to familiarize himself with their programs in order to make desirable features a part of our own. A well kept list of speakers and demonstrators with suitable notes as to their varying degrees of success as lecturers, and as to the reception of their subjects, will be of great value. In effect, we will develop a mobile school of graduate medical education. We view the possibilities for constructive accomplishment in this entire field as being of great and almost unlimited scope, and entirely beyond the capacities of the Committee as presently operating.

A Subcommittee under the chairmanship and largely by the personal activity of Dr. Hawkes, has for some years investigated the need for a medical school in New Jersey. During the past few years, a number of medical schools have been established or authorized in other states, and Dr. Hawkes has been in frequent communication with the authorities of these schools, and has accumulated much data pertaining to the entire problem. Following the establishment of the New Jersey Medical College Commission by the Legislature and the Governor in 1950, he has been in frequent consultation with the members of the Commission, and because of his accumulated knowledge on the subject, has been most helpful to them.

At a meeting held in October 1950, the present and proposed program of the Medical Education Committee was presented to the Trustees of the State Society, and the need for a full time executive secretary and staff was suggested. The Trustees thereupon authorized the Committee on Medical Education to solicit financial support for such a program, and to confer with the President of Rutgers University and his associates, as to the possibility of putting such an expanded program into operation in association with the University. Dr. Decker and the Chairman of the Committee had a conference with Professors Norman Miller and Maurice A. Chaffee, and discussed the matter with them in great detail. Following this, the Chairman received a letter from Professor Miller stating that he had been informed that the University would be happy to have a physician employed by The Medical Society of New Jersey in this capacity assigned to the University with some such title as Technical Adviser in Medical Education, and assuring the Chairman that the University would undertake to provide suitable office space for such a representative. For this position, we would expect to procure an experienced professional medical educator and administrator such as the dean, or assist-

ant dean, of an established medical school. The proper salary would be $12,000 to $15,000 per year. He will need a full time secretary and an operating budget to cover office expense and travel. This budget should not be less than $20,000, and perhaps somewhat more. It has been suggested that the project be established on a three to five year basis. At the end of that time, the success or failure of the project should be evident, and it could be continued or discontinued as then seemed wise. Looking forward with enthusiasm to the entire program, our Committee fully expects that it will be a great success and that it will be finally absorbed into the medical school when this is established; and that in the meantime it will provide a very valuable means of graduate education to the medical profession, and thereby will be of great benefit to every community, and to the state as a whole.

PUBLICATION

J. LAWRENCE EVANS, JR., M.D., Chairman, Leonia

During the year 1951, THE JOURNAL of The Medical Society of New Jersey corresponded almost exactly in size and distribution of content with its composition during 1950.

The net cost of publishing our JOURNAL during 1951 was $4239, or 82c per member. This may be compared with $5000 ($1.00 per member) for 1949, and $3674 (71c per member) for 1950.

The financial gain from increased advertising rates in 1951 was offset by several factors. Costs of publication increased twice during the year, and again by 6 per cent in February 1952. We also now send the JOURNAL to 135 non-paying members of the Society, who are in military service.

Publication costs included approximately $375 for the questionnaire sent in May 1951 to all members of the Society, asking their opinions concerning any changes in content or format of our JOURNAL. Attention is invited to the July 1951 issue of the JOURNAL, delineating results obtained from the questionnaire.

In August 1951, the JOURNAL devoted 17 pages to printing the Charter, Constitution and By-Laws of The Medical Society of New Jersey. During the year, space was allotted for the Medical-Surgical Plan and for Public Health News for the Physician.

Dr. Rowland D. Goodman, II, was appointed Editorial Associate without salary on January 6, 1952, and has lent his interested assistance to our capable editor, Dr. Henry A. Davidson.

We have again been grateful to Mrs. Armstrong and Mrs. Madden for their invaluable services in connection with the many material aspects of publication.

Your Publication Committee welcomes suggestions addressed to its Chairman from any interested members of The Medical Society of New Jersey. We look forward to another successful year.

MEDICAL DEFENSE AND INSURANCE

J. WALLACE HURFF, M.D., Chairman, Newark

PROFESSIONAL LIABILITY PROTECTION

The Medical Defense and Insurance Committee has met and reviewed the year's experience and discussed with representatives of the insurance company many problems pertaining to our professional liability protection.

We are pleased to report that 4192 members of the Medical Society are insured. This is the highest number on record. The survey of claims corresponds to the present inflationary period in which there is a definite increase in the cost of litigation, as well as in claims paid. The number of claims reported is ten fewer than a year ago, but the losses paid out were $20,726 more.

Our members have been responsive to the committee's recommendation for increasing their coverage. In 1950-51, over 1100 insured members carried the minimum limits of $10,000 and $30,000. The number carrying the

minimum fell to 753 during the current year. We again urge that every physician review his present protection status from a liability standpoint; and we emphasize the need for maintaining *adequate* insurance to protect their resources, considering the increased cost, along with a higher claim trend. The Committee is frequently faced with serious claims where the doctors are not sufficiently protected, and are confronted with the possibility of definite, personal financial loss.

The Committee to date does not anticipate increase in the premium rates for the ensuing year; but this cannot be decided until the insurance company has completed compilation of their experience record.

In the application for medical liability insurance is a series of questions pertaining to certain hazardous procedures. We recommend an additional question be included as follows: "Do you perform electric shock treatments at your office?" This is necessary due to the experience of the past year in which were reported a number of claims resulting from shock therapy.

ACCIDENT AND HEALTH INSURANCE

There has been a further increase in the number of our doctors participating in the group accident and health insurance policy our Society has in effect with the National Casualty Company, through E. & W. Blanksteen of Jersey City. More than 3300 of our members are now insured under this program, representing 75 per cent of the eligible membership. We are proud to report a splendid growth in our accident and health volume in which there has been an increase of about 600 doctors insured.

During the past year $150,000 of claim monies was paid out by the Company to 373 claimants, which is an increase of $50,000 over the preceding year. The lowest claim was for $6.66 and the highest for $2583, with a number of these claims still running. No cases were referred to the Committee for arbitration.

The National Casualty Company's plan, which was fathered in this state by our Committee twenty years ago, is continuing to meet with approval by other professional societies throughout the country. The American Dental Association recently adopted a modified version of our plan for the benefit of all of their members throughout the country.

CONCLUSIONS

1. We recommend the renewal of our professional liability contract issued by the U. S. Fidelity and Guaranty Company, through our official broker, Faulhaber and Heard, Inc.

2. We recommend renewal of the group accident and health contract with the National Casualty Company, through the E. and W. Blankensteen Agency.

3. We find that both these contracts have been of inestimable value in the promotion of our insurance program and in furnishing the medical profession with the most comprehensive coverages available at the lowest possible cost.

WOMAN'S AUXILIARY

Lewis C. Fritts, M.D., Chairman, Somerville

During the past year the Woman's Auxiliary has been very active. One of the great helps has been the establishment of an auxiliary office in the Medical Society Headquarters at Trenton. Funds for this were provided by the Trustees, following the Annual Meeting in May of last year. This office has greatly facilitated the work of the officers of the Woman's Auxiliary to The Medical Society of New Jersey.

Membership has increased by 141 members, reported by thirteen counties. There are now approximately 1800 members of the Woman's Auxiliary in the state.

The ladies have been very active in obtaining more scholarship grants for student nurses. They have been active in increasing the subscriptions of *Today's Health*. The Auxiliary has put out spring and fall *News Notes* to over 4000 members and prospective members.

The New Jersey Rural Health Program slogan, "Help Yourself to Health", has been adopted as a theme of the national meeting on rural health.

The Woman's Auxiliary is taking a more important place in the plan of the State Medical Society and we congratulate their officers for a job well done.

SCIENTIFIC EXHIBIT

William W. Hersohn, M.D., Chairman, Margate City

The Scientific Exhibit will again feature the work of members of The Medical Society of New Jersey. A select few out-of-state exhibitors have been given space. Although the floor plan has limited us to twenty-five exhibits they will be quite diversified and, as a result, be of interest to more physicians.

SCIENTIFIC PROGRAM

Johannes F. Pessel, M.D., Chairman, Trenton

The 185th annual meeting of The Medical Society of New Jersey, held at Haddon Hall in Atlantic City, is now history. We attempted the experiment of presenting only two groups of subjects in an effort to give all an opportunity to hear something of allied specialties, as well as to make the field broader for the general practitioners. Since some groups seemed opposed to this type of Annual Meeting, it was dropped in favor of sectional meetings.

The scientific program for the 186th annual meeting is again divided into various specialties as the result of the annual meeting of your program committee with the officers of the State Society in September 1951, when such a plan was adopted. Nineteen sections wanted to meet individually in 1952. As this would necessitate four to five sectional meetings running concurrently, it was deemed impractical and, by motion, it was decided to have all but three sections meet in alternate years.

It was agreed that the sections on General Medicine, General Surgery and General Practice should meet each year; and the remaining sixteen sections should meet on alternate years.

We wish to thank the section chairmen, their secretaries and associates for the very fine program that they have set up in their departments. Sections which are not able to present papers this year will have time and space available to them next year. The results of our new program of sectional meetings can best be evaluated at the end of the coming session.

The Scientific Program Committee requests the endorsement of the House of Delegates on the actions taken by your Committee and Section Officers on the following for recommendations:

1. Section programs should be planned for the interest of the general membership of the Society.
2. The sections on General Medicine, General Surgery, and General Practice will meet yearly.
3. The remaining sixteen sections will meet on alternate years.
4. Previous actions of the Committee, Section Officers, Trustees, and the House of Delegates will be rescinded upon adoption of these recommendations, if inconsistent therewith.

I wish to thank the members of my Committee, Section chairmen, and Section secretaries for their interest and helpful advice. It is they who are responsible for the excellent program for 1952.

WELFARE

Samuel Blaugrund, M.D., Chairman, Trenton

For many years, the Officers, Trustees, and the various chairmen, and members of the subcommittees of the Welfare Committee, have been deeply concerned with the mechanics of transmitting information and responsibility from a state level to a local level. This has been a serious bottleneck, in the transaction of business of The Medical Society of New Jersey for years.

During the past year, efforts were made to correct this. It is a pleasure to report progress in this important phase of our work.

During the past year, the need for a medical school in New Jersey, problems involving Medical-Surgical Plan, Hospital Service Plan and physician and hospital liabilities progress have been studied and surveyed, and I am glad to report on these important projects.

I express appreciation to the officers, trustees and the members of all subcommittees for their cooperation and splendid efforts of keeping our membership informed on all phases of the problems confronting the medical profession of New Jersey.

SPECIAL COMMITTEE TO THE WELFARE COMMITTEE

MEDICAL SCHOOL

STUART Z. HAWKES, M.D., Chairman, Newark

During the year the Special Committee on a Medical School received a great deal of help and support from various elements of The Medical Society of New Jersey.

At the last Annual Meeting an exhibit was given special placing so as to draw the greatest possible attention. This portrayed the steps that had been taken to that time in bringing a medical school to the state. It also attempted to present the functions of a medical school in relation to present day needs of New Jersey.

In July, two members of the Committee on Medical Education of the American Medical Association, Dr. Anderson and Dr. Weyskotten visited the three proposed sites for a medical school. They made a preliminary survey and discussed possible factors with each group, as to what would be needed, what could be expected, and the relation of each site to the proposed school. They again returned in August to make a final survey and to render a report.

This report was requested by Senator Alfred C. Clapp as part of the Legislature's study of a medical school. During both these visits officers of the State Society and of your Committee met with Dr. Anderson and Dr. Weyskotten to aid them in obtaining information and to receive the benefit of their advice and counsel. Their report was submitted to Senator Clapp and filed with The Medical Society of New Jersey as part of the study for a medical school. The report found a need for a medical school and also included many of the details of importance in its founding.

Through the Department of Education, under the auspices of Commissioner Bosshart, another survey was made by several medical school deans. They visited the same three sites and went over the existing possibilities in each place. A similar report was made by this committee and recommendations were then submitted to the Department of Education of the state.

Last fall, meetings were held with representatives of Rutgers University to determine if cooperative efforts could be developed between our society and the University, to develop further and to form plans for promulgation of the school. This effort has culminated in cooperation between Rutgers University and the Medical Society to inform the people of New Jersey on the need for a medical school and its advantages.

The Commissioner of Education will call a meeting at which all levels of representation in the state will discuss the problem.

It is thought that at least a year of education will be necessary to inform the people before any such issue is put to a vote to obtain the necessary money.

The Woman's Auxiliary is planning a Public Relations Day on April 30, to start publicity rolling in connection with a medical school. The need, the effect on New Jersey, the advantages to our different health elements within the state will be emphasized at this meeting.

I should like to thank the Trustees and the officers of The Medical Society of New Jersey for their generous cooperation in this effort.

SUBCOMMITTEES

LEGISLATION

C. Byron Blaisdell, M.D., Chairman, Long Branch

At this time S-139, licensing chiropractors under their own Board, has passed the State Senate (11-9) and the Assembly (31-20). Its fate rests with Governor Driscoll, who can sign it or exercise his power of veto.

In as much as this piece of legislation is of greatest interest to us as physicians, the report of this Committee is being held for presentation at the time of the annual meeting.

MEDICAL PRACTICE

Albert B. Kump, M.D., Chairman, Bridgeton

The Subcommittee on Medical Practice and its component Advisory Committees began the administrative year with numerous problems submitted by the current administration. The Advisory Committees were conscientious in their endeavors and their studies made possible the resulting recommendations of the Subcommittee on Medical Practice. An Advisory Committee was established under the direction of Clarence B. Whims, M.D., pertaining to group practice. It is the purpose of this committee to set up standards for group practice and secure cooperation with other branches of medical practice.

All Advisory Committee chairmen have been diligent in their participation and formulation within the Medical Practice Committee. The recommendations brought forth are evidenced in the annual reports of the respective Advisory Committees and therefore are omitted here.

The year has been devoted to the development of recommendations beneficial to the public and the physicians serving the public. It has been a pleasure to be a part of a committee so actively interested and so generally helpful. My appreciation to each member is sincere.

PUBLIC HEALTH

Joseph I. Echikson, M.D., Chairman, Newark

The Public Health Committee continued the activities of the previous year and attempted to solve the various problems which came to its attention. The Committee has continued to stress the need for uninterrupted activity with those groups which concern themselves with problems related to health. The Committee has also urged that our representatives to the various agencies take an active part in their activities. The Committee has attempted to see that all public agencies in need of medical guidance or participation use only trained medical specialists for these purposes. This program is becoming progressively more effective. Welfare agencies realize the benefits to be derived from the advice of skilled medical advisers rather than from quasi-medical advisers.

I wish to thank the members of the various advisory committees. They have been most helpful. Without their advice our program could not have been carried out so effectively. I also wish to thank the officers of our Society for their advice, guidance and indulgence.

(1) It should be called to the attention of all cooperating groups that it would be best to discuss any publications or releases with The Medical Society of New Jersey before they are released to the public. The need for this became evident with regard to the "Polio Poin-

ters" for 1951 issue by the National Foundation for Infantile Paralysis. If this had been discussed with the Medical Society before it had been published and released much misunderstanding could have been avoided.

(2) The Committee recommended that an intensive study of the "Cardiac in Industry" be rapidly pursued so as to correct the present situation in which many victims of Cardiovascular Disease find it difficult to obtain employment. This program should be discussed and discussion should be held with both labor and management to acquaint them with the facts, and ultimately lead to a better understanding on the part of all concerned through intense educational program.

(3) The Committee recommends that all agencies that need medical advice and consultation be indoctrinated with the idea that only properly qualified medical specialists should be used for these purposes.

(4) The Committee recommends that better publicity be given to the program of radio-isotopes which has been instituted by the New Jersey Division of the American Cancer Society. Emphasis should be placed upon not only the details of the benefits to be derived from such a program but also of the availability of the facilities which have been provided.

(5) The Committee recommends an intensive study of the problem of Human Biologic Defense. A study program is now under way but the Committee feels that its tempo should be accelerated.

PUBLIC RELATIONS

Joseph E. Mott, M.D., Chairman, Paterson

At the Committee's organization meeting last June, the principal points of our 1951-52 program were outlined as follows:

1. Assist county societies in the promotion of
 a. Voluntary health plans
 b. County health councils
 c. County press conferences
 d. Planned publicity for handling the medical indigent
 e. Continued emphasis on Doctors' Emergency Service
 f. Cooperation with Woman's Auxiliary in use of A.M.A. broadcasts
 g. Cooperation with Woman's Auxiliary in all PR activities
2. Continuation of present Health Education Program
 a. *Health Hints* every two weeks
 b. *Junior Health Hints* monthly
 c. A.M.A. radio broadcasts
3. Continuation of present internal promotion program:
 a. *Membership News Letter* monthly
 b. *Quarterly News Letter* to Cooperating Agencies
4. Press conference, combined with county PR and Speakers' Bureau chairmen conference, state-wide, to be held in November
5. Continuation of liaison with Blue Cross and Blue Shield plans
6. County PR conferences with members of State PR Committee
7. Speakers' Bureau Service
8. Monthly news release to county society *Bulletins* and county PR chairmen
9. Quarterly reports from county Woman's Auxiliary PR Committees
10. Quarterly reports from county PR Committees
11. Promotion of a medical school in New Jersey
12. Publication of *Handbook of The Medical Society of New Jersey.*

Subsequent committee meetings, held in September, December and March, were devoted to placing the program into operation and to maintaining good medical public relations at a high level in New Jersey.

1. *Assist County Societies:* Serious effort was made to stimulate interest in good medical public relations at the county level. The Executive Officer bore the major share of this work in his visits to the county societies. Also, the Subcommittee on Public Relations was sufficiently enlarged to gain representation from all areas of the state. Articles appeared regularly in the monthly *Membership News Letter* conveying the message of the State PR Committee to the counties. The use of the Quarterly PR Activity Report, a one sheet, 10 item prepared form, appeared to stimulate PR interest in the counties. Activities relative to the following items were requested from the county PR Chairman every three months:

1. PR Committee meetings held
2. Doctors' Emergency Service
3. Voluntary Health Plans
4. County press conferences
5. Care of the medically indigent

6. Use of A.M.A. transcribed programs in local stations
7. County Health Councils
8. Speakers' Bureau
9. Emergency Education Program.

Eighteen county society chairmen cooperated in returning the reports, which, when analyzed, revealed the following: 13 county societies held at least one Public Relations Committee meeting. One county organized a Public Relations Committee for the first time in its history. Fifteen counties reported Doctors' Emergency Service Plans operating, one reported as poor, several as fair, many as good and a few as excellent. Eight county societies reported action promoting Voluntary Health Plans; 7 reported holding county press conferences; 12 reported satisfaction in care of the medically indigent; only 4 reported A.M.A. broadcasts in use in their area; 5 reported action in forming County Health Councils. Two County Health Councils (Monmouth and Passaic) are already in operation. All but 3 of the counties indicate excellent Speakers' Bureau Activities; and 3 counties reported action on the Emergency Education Program. The two activities most emphasized in the reports were the Doctors' Emergency Service and the Speakers' Bureau, both activities, apparently gaining emphasis in all areas of the state.

Your chairman extends his sincere appreciation and thanks to the County PR Chairmen who cooperated in returning the Quarterly Reports.

2. *Health Education Program:* This program continues to be well received. The Executive Officer has rendered excellent service in preparing *Health Hints* regularly under the pen name, "Michael S. Newjohn, M.D.", coined by your Subcommittee on Public Relations and registered with the State Board of Medical Examiners. This year, *Junior Health Hints,* four per month, sent out to over 1600 school teachers, were prepared by the members of your Subcommittee on Public Relations under the direction of the Executive Officer who edited the copy. The complete year's set (32 articles) will be prepared in a booklet form for future service. Your chairman commends the Executive Officer for his sincere efforts and interest in keeping this phase of our Health Education Program very much alive. Continued efforts were made to maintain an interest throughout the state in the use of A.M.A. radio broadcasts. In some instances the Woman's Auxiliary conducted much of this work.

3. *Internal Promotion Program:* The monthly *News Letter* and the *Quarterly News Letter* to Cooperating Agencies are now being prepared and edited by the Executive Officer. Much favorable comment has been received concerning the merit and quality of both publications which have done much to stimulate good medical public relations.

4. *State-Wide Press Conference:* For the past three years, we have conducted an annual state-wide meeting between representatives of the medical profession (society officers, state society committeemen, county PR chairmen and Speakers' Bureau chairmen) and members of the press, radio and television enterprises in New Jersey. The theme of our 1951 meeting on November 13 was "Progress Through Cooperation" through which we planned to stimulate sufficient interest to develop and formulate a "Code of Cooperation" between the medical profession and the press, radio and television groups. The speakers included the president of the New Jersey Press Association, who spoke on "The Newspaper as an Aid to Medical Progress", an Executive of the New Jersey Broadcaster's Association who spoke on "The Radio and Television as Aids to Medical Progress" and Dr. Russell S. Boles, of the Graduate School of Medicine, University of Pennsylvania, well known for his articles in the A.M.A. *Journal* on public relations and the press, who spoke on "Modern Medicine and Public Relations". A Necessary Partnership for Progress." We invited our Woman's Auxiliary PR Chairmen to attend the affair, in addition to the officers of the New Jersey Bar Association and the New Jersey Hospital Association. At the conclusion of the meeting, which was received enthusiastically by those present, a volunteer committee representing the press and radio, consented to prepare and formulate, in cooperation with your Subcommittee on Public Relations, a "Code of Cooperation" for New Jersey. This joint committee has met and is in the process of drafting a suitable *Code* for adoption by The Medical Society of New Jersey and the New Jersey Press Association and allied groups. Complete details will be submitted in a supplementary report.

5. *Liaison with Blue Cross and Blue Shield Plans:* Your Subcommittee on Public Relations has continued to maintain a keen interest in promoting Voluntary Health Plans by all means at its disposal.

6. *County PR Conferences:* Your Subcommittee on Public Relations was enlarged in membership in order to include public-relations minded individuals from all areas of the state.

The members of the committee, in many instances, county PR Chairman, played the major role in bringing good medical public relations to the county level.

7. *Speakers' Bureau Service:* Your Executive Officer has given valuable service in fulfilling numerous speaking engagements throughout the state. The quality of his talks, his tact, excellent delivery and his dignified sincerity have been a tremendous factor in elevating the prestige of the medical profession in this state. Speakers' Bureau activities on a county level are very well organized.

8. *Monthly News Releases:* This program of internal promotion has not been yet developed to its fullest value.

9. *Woman's Auxiliary:* Your Subcommittee encouraged cooperation with the work of the Woman's Auxiliary on both state and county levels. The Woman's Auxiliary State Public Relations Chairman attended, by invitation, the regular meetings of your Subcommittee on Public Relations and took an active part in many of the discussions. Approving the Fifth Annual Spring Conference conducted by the Woman's Auxiliary to The Medical Society of New Jersey entitled, "The Community Plans for Good Health Through County Health Councils and Civil Defense", both the Executive Officer and your Chairman participated in the program. Approval has recently been given to the Woman's Auxiliary for a public relations conference to be held by that group in April. The morning session will be devoted to "Why New Jersey Needs a Medical School" and an afternoon session to "What a Medical School Offers to New Jersey".

10. *Quarterly Reports from County PR Committees:* (See 1.)

11. *Promotion of Medical School in New Jersey:* Your Subcommittee has cooperated with the special committee for a medical school for New Jersey. All newspaper releases, announcements et cetera, are being prepared, edited and released through your Subcommittee on Public Relations.

12. *Handbook of The Medical Society of New Jersey:* With the approval of the Executive Committee, your Subcommittee is studying the feasibility of publishing a *Handbook of The Medical Society of New Jersey* entirely devoted to medical public relations. This study is incomplete at this time.

With the approval of the Executive Committee, your chairman participated in the organization meeting of the Council for Local Public Health Services of New Jersey, held at Princeton, on November 14, 1951. With the approval of the Board of Trustees, your Chairman (by invitation from the Public Relations Department of the American Medical Association) participated in the program of the Annual Medical Public Relations Conference in Los Angeles last December. He spoke on the panel "Where Do We Go From Here", with the subject "Public Relations Goals for State Societies".

This Committee congratulates the Woman's Auxiliary on its constructive work in all public relations activities. This Committee sincerely appreciates the help and guidance given us by the administrative staff and the Executive Officer. Your chairman extends his sincere and most grateful appreciation to the members of the Subcommittee on Public Relations who attended the meetings regularly and gave willingly of their time and effort to promote the program of public relations as herein described.

RECOMMENDATIONS

A medical public relations program consists of two phases: (a) a constructive program to win public goodwill; and (b) a publicity program. The two must be continually stimulated, maintained very much alive, day in and day out, reorganized from time to time to avoid lethargy, and promoted with constant drive. Incessant forward planning is a necessity, with a coordinated continuity linking past events. With this in mind, this committee offers the following recommendations for the coming year.

1. Continued interest in county society public relations activities.
2. Continuation of the present Health Education Program.
3. Continuation of the present internal promotion program.
4. A planned promotional campaign for a medical school in New Jersey, in cooperation with the Special Committee.
5. A one-day speakers bureau training program of indoctrination in promoting a medical school for New Jersey.
6. Adoption of a *Code of Cooperation* with the press and allied groups.
7. Publication of a medical public relations handbook.
8. An annual state-wide dinner-meeting with the press and allied groups in the interests of progress through cooperation.

MEDICAL PRACTICE ADVISORY COMMITTEES

GENERAL PRACTICE

D. Ward Scanlan, M.D., Chairman, Atlantic City

The Welfare Committee amended our committee's recommendation and adopted the following: "That the county medical societies include annual A.M.A. dues in addition to county and state society dues in their annual billing to their members."

The option of paying dues directly to the national office of the A.M.A. was eliminated since this procedure is not acceptable to the A.M.A.

Our committee's recomendation was amended and the Welfare Committee adopted the following: "That physicians' names, addresses, and telephone numbers be listed in the classified sections of the telephone book, and that general practitioners be marked with an "x" or asterisk, the mark to be so defined to designate to the public a general practitioner."

That in the classified section, physicians be listed under the group title "Physicians and Surgeons—Members of The Medical Society of New Jersey".

The placement service for physicians was given to this Advisory Committee by the Medical Practice Committee. Since then, the State Society has established a Physicians Placement Service in N. J. with Dr. Marcus H. Greifinger, Newark, as Chairman. The Chairman of the Board of Trustees, Dr. David B. Allman, has requested this Advisory Committee on General Practice to turn over all our papers to Dr. Greifinger, with which request we have already complied.

The Advisory Committee on General Practice was asked to make a survey of the counties to determine average fees for office calls, house calls, night calls, and emergency calls.

Out of the twenty-one counties, fourteen counties complied with this request. The average house call charge for fourteen counties, in the daytime, is $4, a few charge $5 to $10. The night calls average between $5 to $10 per call. Average for emergency calls is $10.

A couple of the counties still charge $2 to $3 for office calls. The average office call is $3 throughout the state. One county reported obstetrical fees as $50 to $100.

GROUP PRACTICE

Clarence B. Whims, M.D., Chairman, Ventnor

As Chairman of the Advisory Committee on Group Practice to your group, I wish to submit that one meeting was held throughout the year which was very poorly attended. However we did discuss some of the problems relating to group practice and have two suggestions to make to you and the overall committee.

It is desirable that a survey be conducted by the State Medical Society to determine existing facilities for medical care which are furnished by the different groups in the state. We felt that a list of the clinics, their locations, their work capacity, the size of their staffs, et cetera, might be useful at some future date, particularly with reference to medical emergencies.

Some way should be found for diagnostic study and perhaps some ambulatory care to be given to individuals who now participate in Blue Cross and the Medical-Surgical Plan of New Jersey. Diagnostic studies are not now a part of the plan. It was the feeling of the committee that much of the work now done in the hospital could be done in the offices, particularly of those of clinics or medical groups. A full discussion of the desirability of saving hospitalization was gone into and this is the basis for this recommendation.

I regret that this Committee has been so inactive but it was impossible to get the membes together to discuss the problems relative to group practice.

HOSPITAL RELATIONSHIPS

Florentine M. Hoffman, M.D., Chairman, New Brunswick

During the year now closing your committee has studied the following problems: exclusion of all medical services from hospital service contracts and inclusion of all these services in medical-surgical plan contracts; measures to combat hospital usurpation of medical services and unjust competition by hospitals; plans for specific steps to restore the prestige and welfare of physicians in hospitals; admission of cases of acute poliomyelitis by general hospitals which are able to give proper care and provide adequate isolation; and hospital solicitation campaigns for funds to expand or build new facilities.

Reports of our studies and conclusions have been submitted to the Subcommittee on Medical Practice and through that committee to the Welfare Committee and the Board of Trustees.

NURSING

Andrew C. Ruoff, M.D., Chairman, Union City

This Committee has, in effect, accomplished nothing, so far as any recommendations are concerned on the pressing need for nurses in New Jersey, or in the nation as a whole. There are many reasons for this. The shortage of nurses is serious. The prime cause is largely economic. The stress and strain created by several wars, the general social evolution, and the need for earning enough to keep body and soul together are as pressing in the nursing profession as they are in other walks of life. We are dealing with human beings, and nursing inherits the trials and tribulations inherent in the complex system of maintaining a standing and providing a sustenance. In the overall field of nursing, there are many forces at work. Not all of these forces have in mind the problem of bringing more nurses into the field of nursing. Nursing standing in this state should be kept at a high level. In the past year, your Chairman has carefully studied the "Nursing Act", which was created to regulate and control the teaching and practice of nursing and to prescribe penalties for violations. At present The New Jersey State Nurses Association is sponsoring an amendment, making it compulsory for all graduate nurses in New Jersey to take examinations leading to the degree or license of R.N. This problem was presented to my Committee, and I met with members of the State Nurses Association. The State Nurses Association has some very diligent, conscientious workers. They have the profession of nursing at heart. Your Chairman feels that the Nursing Act as it stands, throws sufficient safeguards around the practice of nursing, and does not need any further safeguards. However, the group representing the State Nurses Association felt that further safeguards were needed. The problem, in effect, is theirs. As Chairman of your Nursing Committee I felt that to amend the Act, as contemplated, might add to the shortage of nurses. The group with whom I conferred felt otherwise. The Nursing Act now on the statute books fails to provide for any cooperation of the Medical Society, and it was your Chairman's opinion that, in this respect, the Act was faulty. I had the assurance of the State Nursing Association that it would lend a willing ear to the problem of nursing as it might present itself to the doctors of the state, who, after all, must have the nurses in the adequate performance of their duties.

With the assurance from the State Nurses Association that they would gladly thrash out the nursing problem with a committee of The Medical Society of New Jersey, my Committee felt that we should give the State Nurses Association our support in the proposed amendment to the Nursing Act.

Your Legislative Subcommittee does not entirely agree with the recommendations of my Committee. What my Committee sought to accomplish was greater cooperation between the nursing profession and the medical profession. The Nursing Act as it stands does, in effect, very well protect the practice of nursing. Nothing much could be accomplished by further amending an Act which, in essence, places the entire control of nursing in the hands of non-medical personnel. In fact, if the amendment, now sought by the State Nurses Association should be enacted, and if thereafter it be found that the entire Nursing Act does,

in fact, act as a detriment to the filling of the nursing ranks, then The Medical Society of New Jersey should have the entire legislation revamped, so that all of the parties concerned could join hands, and have a law enacted which will more rapidly bring more nurses and nurses' aides into the profession. In this connection, there is the matter of cost in training. This has been carefully studied by the Joint Committee for the Improvement of the Care of the Patient on the Ways and Means for meeting the cost of Nursing Education. This committee is composed of representatives of the Medical Society, the Hospital Association and the Nurses Association. My Committee has approved the recommendation of the Joint Committee to have legislation enacted whereby the State would contribute $150 toward the education of each nurse in training in New Jersey each year. This does not contravene the desire of the American Medical Association "that the nursing problem should be met on a state level so far as contributions for the education of nurses is concerned".

Your Committee has gathered much statistical data on the nursing problem in New Jersey and in the United States. The American Nurses Association has published a very complete book, the title of which is, "1951 Facts about Nursing". This is replete with much information and reflects salaries now paid in every branch of the nursing profession. Predominantly, nurses, working for federal government agencies are the better paid.

Something should be done to accelerate the training of nurses and nurses' aides, without impairing the educational quality of nurses. One such plan, namely to have a nurse, as part of her prescribed training, serve as a "nursing intern" with pay, would seem to have appeal. It is my understanding that such a plan is now under way, with Rutgers University cooperating. The plan was instituted in one of the large New York hospitals, whereby one R.N., or graduate nurse, is paid on a *per diem* basis by the hospital, and her services cover several patients. Actually, this does not mean that the nurse would be working harder, because, in small groups, such a nurse could well control the activities of nurses' aides, or auxiliary student nurses.

Your Committee will be glad to pass on the data it has accumulated to the next Committee on Nursing.

Your Committee has been glad to serve you and regrets not having been able to formulate a tangible recommendation on the vexing problem of the scarcity of nurses and nursing care.

PHYSICAL MEDICINE

ELMER J. ELIAS, M.D., Chairman, Trenton

The committee met on March 22. The facts stressed in the past two years still bear repetition and are listed again for information:

1. Departments of Physical Medicine and Rehabilitation should be directed by physiatrists or physicians having a primary interest in the specialty.
2. A well organized and regulated department of Physical Medicine and Rehabilitation should be a requisite of every recognized general hospital.
3. Physiotherapists and technical assistants should be trained and qualified in their work.

Senate Bill 40, licensing physiotherapists in New Jersey has only recently become available and sufficient study of the bill has not been possible to warrant approval of every detail specified in that bill.

The recent edition of the *Manual for Participating Physicians of Medical-Surgical Plan* fails to include payment for services rendered in physical medicine. Exception is taken to this omission. Physical therapy, as practiced in an accredited department, merits the same recognition for service rendered as that given to any other type of treatment. With the rising tide of chronic illness evident at this time and anticipated for the future, it is imperative that the value of physical medicine be established and recognized by not only the Medical-Surgical Plan, but by the entire medical profession.

PHARMACEUTICAL PROBLEMS

JOHN L. VARRIANO, M.D., Chairman, Jersey City

The meetings of the committee were held jointly with the Committee on Professional Relations of the State Pharmaceutical Association. The chairman is appreciative of the efforts of individual members of the committee as well as the cooperation of the State Pharmaceutical Association, and wishes to take this opportunity to thank them.

RECOMMENDATIONS

1. That The Medical Society of New Jersey request the Legislature to correct the discrepancy that now exists in the State Uniform Narcotic Law. The reasons are as follows:

(a) There is no distinction in the penalties provided by the State Uniform Narcotic Act between deliberate and willful criminal violations and the minor and technical infringements that may on occasion be committed by allied medical practitioners.

(b) The intent of the law with respect to provisions relating to allied medical practitioners is to keep narcotic drugs from being obtained through legal sources to satisfy dependence upon, or addiction to, such drugs.

(c) Minor or technical infractions of the law by allied medical practitioners, unless resulting in the deliberate or willful diversion of narcotics to habitual users or addicts, should not be subjected to the severe penalties provided for criminals who are engaged in the illegal narcotic drug traffic.

2. That The Medical Society of New Jersey make known to the Governor its displeasure for his failure to consult with the Society before designating a representative of the medical profession to serve as a member of the State Narcotic Investigation Commission.

3. That The Medical Society of New Jersey oppose (in the interest of public health, safety, and welfare) the distribution of all potentially harmful drugs and medicines, whether in package form or otherwise, by persons who are not qualified by reason of education and training to handle drugs and medicines.

RADIOLOGY

JOHN L. OLPP, M.D., Chairman, Tenafly

The approval, in principle, by the Trustees of a recommendation that medical services be excluded from Hospital Service contracts and be included in Medical-Surgical contracts is encouraging, and it is hoped that its presentation to the Trustees of the Medical-Surgical Plan and those of the Hospital Service Plan will not be delayed.

New Jersey hospital radiologists will be circularized to learn whether they are satisfied with their contracts.

The following recommendations are submitted:

1. That every qualified radiologist have sufficient malpractice insurance coverage.

2. That all radiologic installations be monitored, and the protection checked.

3. That all physicians using fluoroscopes be made aware of the dangers of overexposure to the patient, physician and personnel.

4. That comprehensive medical service contracts be made available to all residents of New Jersey as soon as practical.

WELFARE SERVICES

HAROLD C. COX, M.D., Chairman, Hightstown

At the beginning of the current term, the aim of this committee was to strengthen our system of private practice of medicine, with particular efforts to study the possibility of setting up coverage of the care of the indigent through Medical Service Administration.

Some progress has been made in that direction. A better understanding of the problem confronting physicians and welfare agencies in caring for the underprivileged and needy, was reached, as the result of a conference among representatives of the State Department of Institutions and Agencies, The Medical Society of New Jersey, the Medical Service Admin-

istration and the Medical-Surgical Plan of New Jersey, held on January 16. Meeting in an atmosphere of informality, a free exchange of ideas clarified the problem of assisting and paying for the care of welfare clients. The prevailing thought was that it seemed desirable to establish a single system supported by a single fund to provide a comprehensive medical service, not only for all the special categories of public assistance, but also for the clients of general relief, and in so far as possible, for the medically indigent. It would be desirable to have an intermediary agency operated and controlled by the medical profession, which would carry on all the contacts and relationships with physicians, supervise and administer payments to physicians for professional services and consult continuously with the Department in regard to improvements in medical care. Such an agency, it was suggested, might consider the possible use of the Medical-Surgical Plan to provide through insurance, a part of the medical service. Plans are being made for the future developments of such a program.

At the meeting of the Board of Trustees, on January 6, 1952, two recommendations suggested by the Advisory Committee on Welfare Services were approved. They were:

1. It is recommended that one or two members of the Advisory Committee on Welfare Services be permitted to meet with the interim committee which has been appointed by the Legislature to study the provisions of Chapter 139, Public Laws of 1951, unless the Society is otherwise represented.

2. It is recommended that the Medical Society consider an increase in the fee schedule for the State Board of Child Welfare to $3.00 for an office fee and $4.00 for a home visit.

WORKMEN'S COMPENSATION AND INDUSTRIAL HEALTH

Ralph A. Young, M.D., Chairman, Linden

The Advisory Committee on Workmen's Compensation and Industrial Health was assigned the following two problems:

1. Study measures to correct defects in compensation practice and to improve medical services.
2. Study the operation and general conduct of the Medical Disability Benefits Law and correct abuses.

The opinion of the committee concerning these was:

1. The committee feels that the general level of medical care given to compensation cases is good and they have not observed defects in compensation practice as it relates to medical care. There is no doubt that there are some exceptions to this in individual cases, but for the most part, employers and insurance carriers are insisting on the best medical care and treatment available.
2. The committee approves the appointment of qualified medical practitioners at the community level to provide an independent examination and opinion where there is a difference of opinion about the disability. County societies should initiate systems for naming medical consultants for temporary disability benefits examinations when necessary.

At the request of the officers of the State Society, a meeting of the Advisory Committee on Workmen's Compensation and Industrial Health and the Special Committee on Temporary Disability Benefits was held on December 19, with representatives of the Division of Employment Security of the State Department of Labor and Industry. At the conclusion of this deliberation the following recommendations were approved by the combined committees and were submitted to the Board of Trustees for consideration:

(a) That the Board of Trustees request county societies to initiate systems for naming medical consultants for temporary disability benefits examinations when necessary, recommending some modification of the system used in Atlantic County, which could be adapted to fit their particular needs, as the most efficient means of carrying out this program.
(b) That an educational program be developed to make physicians aware of the seriousness of the problem of malingering under this program and educate the physician and public alike regarding the necessity of viewing the program as a form of insurance and not as something received for nothing.

The Trustees on January 6, 1952, approved recommendation (a) and suggested that county societies initiate systems for naming medical consultants for temporary disability benefits examinations when necessary.

The Trustees approved recommendation (b) in principle but stated that it is the duty of the State Disability Benefits Commission to initiate such a program with which the society would be glad to cooperate.

PUBLIC HEALTH ADVISORY COMMITTEES

ADULT DISEASE CONTROL

NATHAN SWERN, M.D., Chairman, Trenton

It was felt that a permanent Diabetic Detection Campaign would be of more value to the various communities than an annual detection campaign. It is hoped to organize committees in the various county societies to cooperate with their Tuberculosis Committee, who, in turn, would cooperate with the state tuberculosis detection group taking fluorophotographs at scheduled times.

All reports of positive glycosuria findings should be sent to the appropriate county committee. They should notify the family physician and the diabetic suspect. In this way medical administration and practice will remain in the hands of medical men. The plan should be worked out at future meetings with the tuberculosis detection section of the State Board of Health.

CANCER CONTROL

WILLIAM O. WUESTER, M.D., Chairman, Elizabeth

The cancer program of the society has again gone forward during the past year. The five point program has been augmented by two additional parts, namely Part II A and Part VI.

PART II A

Through the cooperation of the New Jersey Society of Clinical Pathologists a program for the reading of Papanicolaou Smears was made available to all cancer patients in New Jersey. This was developed by the Advisory Committee on Cancer Control of The Medical Society of New Jersey; The Medical Advisory Committee of the American Cancer Society, New Jersey Division, Inc., and the New Jersey Society of Clinical Pathologists. The primary purpose of this program is to cope with the increasing number of suspected cancer patients and to impress the practicing physician with the fact that there is a method which may bridge the gap between clinical examination and tissue biopsy.

No charge for this service by these pathologists is made to patients who are unable to pay and containers and slides for the mailing of the specimens in addition to instructions to the physicians are supplied free by the New Jersey Division of the American Cancer Society. Semi-private and private patients are expected to pay the pathologists' usual fee for this service.

PART VI

Through the cooperation of the Advisory Committee on Cancer Control of The Medical Society of New Jersey; the Medical Advisory Committee of the American Cancer Society and the staff of the Newark Beth Israel Hospital, arrangements were completed with the United States Atomic Energy Commission for the establishment of an isotope center. This center was officially opened on February 1, 1951, at Beth Israel and the American Cancer Society assisted financially toward the equipment installed in the two laboratories of the center. In addition to this financial aid a program has been developed to reimburse the center for the cost of treatment to indigent or medically indigent patients. This reimbursement covers the cost of preparing the radio active material for administration to the patient and does not include payment for the isotopes since all material is furnished free of charge by the United States Atomic Energy Commission.

From February 1951 to February 1952 two hundred and fifty patients were treated at the center, 65 of whom had possible malignancies. Twenty-nine cases were financed by the American Cancer Society.

During the coming year this service will be expanded through the opening of branch isotope centers to handle radio active phosphorus

in various points throughout the state. Through this expansion an additional service will be provided all cancer sufferers in New Jersey.

The New Jersey Division of the American Cancer Society was incorporated in December 1945. At that time, the Advisory Committee on Cancer Control of The Medical Society of New Jersey was named under the division's by-laws as the Medical Advisory Committee for the Society. Since that time this committee has screened all proposals for medical projects for which the American Cancer Society's funds would be expended.

A total of $1,321,509 has been approved by the committee for expenditure by the county chapters of the American Cancer Society for clinic equipment, radon seed, medications, visiting nurse services and nursing and clinic help and care of the needy cancer patient under the home care program.

Close cooperation between the laymen and the medical men in the cancer program has been due, in large part, to the definition of responsibilities by which each group clearly acknowledged its responsibility and defined its authority. By this formula, the two groups have been functioning well since 1945. Under this definition it is the responsibility of the laymen to raise the funds to be spent for the cancer control program. During the past five years, over four and one-half million dollars have been raised by the American Cancer Society in this state. Of this, the New Jersey Division has turned over to the national society $1,130,000 for the national research program and $680,000 for national educational activities. The balance has been spent, or is being spent, for service and education projects in this state.

Outstanding cooperation has been exemplified by the physicians of the society by their support of the cancer clinic program. This phase of the American Cancer Society service continues to grow and reports received from the thirty-nine clinics in operation throughout the state reveal that 22,089 visits were made to these clinics by indigent or medically indigent persons last year of which 7246 visits were made for x-ray therapy. One thousand eight hundred and seventy-eight new patients were referred for examination of whom 801 were diagnosed as malignant.

The following are the clinics which received financial aid during the past year under Part IV of the American Cancer Society program. Negotiations are pending at present for the opening of three new clinics during the coming year.

All Souls Hospital, Morristown; Atlantic City Hospital, Atlantic City; Barnert Memorial Hospital, Paterson; Bayonne Hospital and Dispensary, Bayonne; Beth Israel Hospital, Newark; Bridgeton Hospital, Bridgeton; Burlington County Hospital, Burlington; Christ Hospital, Jersey City; Cooper Hospital, Camden; Dover General Hospital, Dover; East Orange General Hospital, East Orange; Elizabeth General Hospital, Elizabeth; Englewood Hospital, Englewood; Fitkin Memorial Hospital, Neptune; Hackensack Hospital, Hackensack; Holy Name Hospital, Teaneck; Irvington General Hospital, Irvington; Lutheran Memorial Hospital, Newark; Mercer Hospital, Trenton; Monmouth Memorial Hospital, Long Branch; Morristown Memorial Hospital, Morristown; Muhlenberg Hospital, Plainfield; McKinley Hospital, Trenton; Newcomb Hospital, Vineland; Newton Memorial Hospital, Newton; North Hudson Hospital, Weehawken; Passaic General Hospital, Passaic; Paterson General Hospital, Paterson; Perth Amboy General Hospital, Perth Amboy; Presbyterian Hospital, Newark; St. Barnabas Hospital, Newark; St. Francis Hospital, Trenton; St. Joseph's Hospital, Paterson; St. Mary's Hospital, Hoboken; St. Mary's Hospital, Passaic; St. Michael's Hospital, Newark; Underwood Hospital, Woodbury; Warren Hospital, Phillipsburg, and West Jersey Hospital, Camden.

In addition to the financial assistance given cancer patients through the clinics, 550 patients received financial help or the family of the patient has received guidance in the care of the terminal cases. This indicates an increase of 252 over last year. This type of assistance is made possible through Part V (Home Care) of the cancer program which was first developed during the year 1949-1950. The records of the state division of the American Cancer Society reveal that the cost of this care for the period September 1, 1950, to August 31, 1951, was $24,440. As the above figures indicate, the number of patients receiving home care has doubled in one year. Each of these cases has been screened to determine if any other agency or government department was responsible for the care. The policy of the New Jersey Division of the American Cancer Society is that all other means of assistance must be exhausted before financial aid is given terminal cases.

Other phases of the Cancer Society's medical program through which assistance is given New Jersey cancer patients who are indigent or medically indigent are as follows:

Special Medications: High cost medications are supplied to the cancer patient by the division. During the past year $12,982.07 was expended by the twenty-one county chapters for this service.

Visiting Nurse Service: Twelve thousand eight hundred and fifty-two visits were made by the 38 visiting nurse associations under

contract with the New Jersey Division. The cost of this service was $21,673.44 for the period September 1, 1950, to August 31, 1951. Visits are made to cancer patients upon the recommendation of the family physician or a cancer clinic and after approval is given by the county chapter involved, payment is assumed by the American Cancer Society.

Radon Seeds: Gold Radon Seeds are made available to the New Jersey physicians for administration to indigent cancer patients in cancer clinics at the expense of the New Jersey Division for which $2844.99 was expended last year.

In addition to providing for the above items $11,404.87 was allocated last year for miscellaneous items of clinic equipment.

As an aid to the 2000 New Jersey physicians who have indicated their willingness to conduct health maintenance examinations in their offices, a health maintenance examination form was prepared and a supply sent to each doctor. It is hoped that these forms will assist the physicians to conduct a complete examination and also that uniform records will be kept on all persons examined for cancer throughout the state.

New Jersey physicians have also cooperated with the American Cancer Society by accepting the chairmanships of the Service and Education programs and have supplied professional speakers for meetings of laymen.

The medical advisory committee of the New Jersey Division has held monthly meetings during the past year at which 137 projects were received and screened for various phases of the program in effect in the twenty-one county chapters. The total dollar value of these projects was $236,293.65.

Without the assistance and cooperation of the laymen of the American Cancer Society it would be impossible for the medical committee to function. The close working relationship between these two groups is reflected in the progressive cancer program now in effect in New Jersey. The committee deeply appreciates the support which it has received from the laymen in the state division and in the twenty-one county chapters.

CARDIOVASCULAR DISEASES

Jerome G. Kaufman, M.D., Chairman, Newark

The Committee on Cardiovascular Diseases wishes to report continued interest and activity in cardiovascular diseases in the state. Acting in an advisory capacity to The New Jersey Heart Association, we met with representatives of the Medical-Surgical Plan to discuss a new fee schedule for participating physicians.

During the year two work classification units have been organized in Newark. One is at the Beth Israel Hospital and the other at St. Michael's Hospital. These clinics are studying the cardiac in relation to industry, particularly from the standpoint of functional capacity and job placement.

The educational program, both professional and lay, has continued on a very high plane. A symposium was held in Newark in March and was well attended by physicians from all parts of the state. The lecture course in cardiovascular diseases for the general practitioner was repeated at St. Michael's Hospital in Newark and was markedly oversubscribed. The increasing interest of the general practitioner in the study of heart disease has been noted throughout New Jersey.

It is gratifying to this committee to be able to report the great progress that has been made in the field of cardiovascular diseases in our state.

CHEST DISEASES

Harry J. White, M.D., Chairman, Metuchen

The Advisory Committee did not have occasion to meet during the past year inasmuch as there were no problems that arose which would make a meeting necessary.

CHILD HEALTH

Frederic W. Lathrop, M.D., Chairman, Plainfield

The Committee is collaborating with the State Department of Health in the preparation of standard regulations for the quarantine and isolation of contagious diseases. The goal is to establish uniform procedures which might be accepted by the local health units throughout the state, so that regulations will be the same in different communities. At present, the variations in quarantine routine from one town to another are confusing to both patients and doctors. Preparation of these standards requires considerable study, so that at the moment we can merely report progress.

CONSERVATION OF VISION AND HEARING

Reinhold W. terKuile, M.D., Chairman, Ridgewood

The Committee on Conservation of Vision and Hearing has continued through 1951 the organizational plans that were begun a year previous.

These involved mainly the formation of similar committees in each county society, and the arrangements with each chairman to coordinate their policies and activities with those of the State Medical Society committee. Nearly every county society in the state now has committees. Previous to this year only a few existed. These committees have been informed of the general aims and policies of the State Society committee. The response has been gratifying.

The various chairmen will be kept informed of our activities with especial regard to standards of procedure and equipment used in School Vision and Hearing testing, as well as any change in policies regarding vision and hearing problems.

This Committee has long felt that our medical societies, both county and state, should formulate definite policies on standard conditions of testing vision and hearing in our public schools and should designate acceptable equipment for this purpose, and the proper procedures and methods to be used. They should recommend standard record and report forms. We are working toward these ends.

School Vision and Hearing tests should be kept on a screening level only, and not considered as diagnostic. Existing school medical facilities for conducting these tests are entirely adequate for this purpose. The members of the county medical society committees on Conservation of Vision and Hearing stand ready to give advice on proper equipment and will instruct the school physician or school nurse when desired.

No one piece of equipment for testing will be practical in all schools. Equipment should be altered to fit the requirements in each case.

This Committee has adopted the following general policies regarding school vision and hearing tests:

(a) That these tests be kept at "screening" level with no attempt at diagnosis.

(b) Children with vision or hearing defects will be taken by their parents or guardians for diagnosis and treatment either to the proper private specialist or to a clinic.

(c) Screening tests should be augmented by both classroom behavior and progress in school when considering the necessity for further specialist study.

(d) Screening tests be done as simply as possible with such equipment as would be used in the ordinary screening test.

(e) The school nurse under medical supervision and instruction is capable of conducting and recording these tests.

(f) All children should be tested before they enter school, either at the school spring round-up, by the proper specialist or in a clinic.

(g) When defects in hearing or vision are discovered, the school examiner shall give the parents or guardians forms to be filled out reporting findings and treatment.

RECOMMENDATIONS

1. It has been repeatedly, and is now urgently requested that The Medical Society of New Jersey seek to place one of its own members on the State Board of Education as a regular member.

2. That the society also seek the appointment of an ophthalmologist or eye, ear, nose and throat physician as official visual consultant to the State Board of Education.

3. That an ophthalmologist or eye, ear,

nose and throat physician be appointed by the State Motor Vehicle Bureau as their official consultant.

4. That recommendations made by the committee chairmen be acted upon when approved by the Trustees.

5. That, if necessary, the Medical Society activate or originate legislation to bring about improvements approved by the Board of Trustees.

6. That the Medical Society adopt a more aggressive attitude when public welfare is at stake; it should actively participate in planned campaigns to protect its professional standards, rather than wait the necessity of fighting back after some other organization has made a move against it.

7. That this Committee be enlarged to include the chairmen of the similar county society committees.

MATERNAL WELFARE

John D. Preece, M.D., Chairman, Trenton

The Maternal Welfare Committee finds considerable satisfaction in the published reports of the New Jersey State Department of Health statistics of 1950. The maternal death rate of .07, indicates that obstetricians of New Jersey are keeping pace with obstetricians of the rest of the world.

The activities of the Committee during 1951 (in addition to the usual duties of field reports and classification of deaths) consisted of three general meetings. The Chairman would like to express his pleasure in the support and interest of the members of the Maternal Welfare Committee. He also wishes to thank the Field Physicians for their help and cooperation and to commend them for their excellent work throughout the year.

During 1951, we have had three new Field Physicians appointed to replace men who had asked to be relieved because of the increasing pressure of private practice.

Other activities included meetings with representatives of the Department of Institutions and Agencies and the Bureau of Maternal and Child Welfare to draw up a revised form for reporting of maternal statistics from hospitals throughout the state. Meetings were also held with the Department of Vital Statistics, and the Bureau of Maternal and Child Health for the purpose of clarifying the classification of neonatal deaths. This is still a major problem in our state and demands further study.

It is the recommendation of the Maternal Welfare Committee of 1951, to the Maternal Welfare Committee of 1952, and the Committee on Child Health that more emphasis be placed on the project of greater neonatal salvage for the coming year so that we may further reduce neonatal mortality in New Jersey.

MENTAL HYGIENE

Harrison F. English, M.D., Chairman, Trenton

The Advisory Committee on Mental Hygiene has met twice in the fiscal year just completed. This year, we have concerned ourselves primarily with two issues: the launching of the previously approved Epilepsy Project, and the preparation of a bill for the certification of qualified psychologists.

This Committee has been given the additional duty of serving as the medical advisory committee to the Epilepsy Project. In this capacity, the Committee has worked in close association with the New Jersey Society for Crippled Children and Adults in accumulating information pertaining to the care and treatment of epileptics, and sponsoring an institute on epilepsy primarily for the orientation of nurses, social workers and other professional groups on problems incidental to the treatment of the epileptic.

In February, we met with a committee of the New Jersey Psychological Association to work out differences of opinion in regard to a proposed bill to certify psychologists, with the aim of discouraging the practice of psychology by inadequately trained individuals.

Several differences of opinion still exist between the medical profession and the psychologists in regard to licensure as compared with certification and the practice of psychotherapy. These differences do not appear to be irreconcilable. It is the hope of this Committee that, in the course of the coming year, a bill to control psychological quackery will be enacted into law.

It is recommended (in order to facilitate the program of the Advisory Committee on Mental Hygiene and to keep the initiative of the mental hygiene movement within the field of medicine and public health where it rightfully belongs) that each county component of The Medical Society of New Jersey be requested to appoint a standing Mental Hygiene Committee.

NUTRITION

S. WILLIAM KALB, M.D., Chairman, Newark

The Committee felt that nutrition should be taught on a state level in all schools as part of a public health program. This is now being done. We believe it necessary to conduct an educational campaign on the control of sweets in the diet, and also one to comprise breakfasts for children. We proposed a "Better Breakfast Week" to take place in October. A program on weight control will be initiated this fall.

REHABILITATION

H. EUGENE READING, M.D., Chairman, Paterson

Cerebral palsy clinics in this state have shown remarkable progress in the care of additional numbers of patients. New construction of 2 large cerebral palsy clinics and provision for the construction of a third clinic are keeping pace with the increase in the cerebral palsy children brought to them as new admissions. The mandatory reporting of any cases of cerebral palsy to the State Health Department has shown the worthiness of this new law. Earlier treatment has, thereby, been started for children who would otherwise not have been brought to the attention of local health agencies. St. Joseph Hospital in Paterson has recently remodeled a ward for the admission and treatment of acute poliomyelitis patients.

RECOMMENDATION

The attention of your Committee has again been called to the use of fluoroscopic machines in shoe stores in New Jersey as a hazard to the child being fitted with shoes as well as to the salesman operating the machine. These fluoroscopic machines are not essential for the fitting of shoes. New York law limits the use of fluoroscopic machines in shoe stores by salesmen to a few hours a month, apparently having in mind the potential dangers of repeated x-ray exposures. This matter is being submitted to the Subcommittee on Public Health for their consideration.

RURAL HEALTH

RALPH M. L. BUCHANAN, M.D., Chairman, Phillipsburg

Under the direction of the Woman's Auxiliary, the Rural Health Program was continued during the past year. To bring urban communities within the scope of the program, six of the nine presentations were set up as a Community Health Program.

Through the media of the Auxiliary *News-Note*, the Medical Society Membership *News-*

Letter, and Junior *Health Hints* to school teachers, the availability of the Rural Health-Community Health Programs was made known.

An audience of 11,000 was reached this year through 56 program bookings. While this represents a greater number of persons reached, the number of actual bookings is less. Your committee and the Auxiliary committee conclude that the present Rural Health-Community Health Programs have served their purposes, and that the time has come for revised programs. The Auxiliary committee is already making progress on the revised programs.

Our committee takes this opportunity to express appreciation to the Woman's Auxiliary and its Rural Health-Community Health Committee for the splendid work they have accomplished during the past year and for the ambitious program they are planning for next year.

SCHOOL HEALTH

Elton W. Lance, M.D., Chairman, Rahway

The work of this Committee has included promotion of the Four Point Program. We have acted in an advisory capacity to the New Jersey Council for School Health and have given assistance in the projects of that Group in its work of implementation of the Four Point Program.

Your Chairman attended the Third Conference on Physicians and Schools held in Highland Park, Illinois in November 1951. A report of this Conference was submitted to the Board of Trustees.

Active participation in school health activities should be continued. New and improved methods of health education should be studied. To this end a meeting on school health services will be held during the Annual Meeting. It is hoped that this will prove of sufficient value to warrant such annual sessions.

No recommendations are necessary except to suggest that the cooperation which now exists between The Medical Society of New Jersey and the bureau of health, safety and welfare of the State Department of Education be supported. This effort can be strengthened by including appropriate divisions of the State Department of Health in the collective effort to improve school health procedures.

COOPERATING AGENCIES

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

THE BOARD OF GOVERNORS

During 1951 the activities of Medical Service Administration have been limited to the operation of the City of Newark Medical Plan. This Plan, designed to meet the needs of the indigent and medically indigent of the City of Newark, a reimbursement plan rather than an insurance plan, provides payment on a fee for service basis for services rendered by physicians of the patients' choice for care of eligible persons confined to their home by illnesses.

The Plan continues to be a successful demonstration of the cooperation of an official health agency with a voluntary agency controlled by the medical profession in solving the problem of medical care of the indigent and medically indigent. It continues to arouse nation-wide interest as a pioneer effort to solve this problem within the framework and approved principles of organized medicine.

The table depicts the experience of the Plan over a seven year period, from 1945 to 1951. Statistics for 1944 are listed in previous reports. The table shows actual costs and reflects the changing economic picture. In interpreting this table we remind you that the indigent are those whose names appear on the welfare rolls of the City of Newark. The

medically indigent are those who, in the opinion of the Social Service Bureau of the City Board of Health, while having sufficient income to meet the routine cost of a satisfactory standard of living, do not have sufficient income to pay for adequate medical care. Since the only fixed, or well-defined group, are the indigent, the cost per capita in this report is limited to the indigent group. It is impossible to estimate the size of the medically indigent population.

As presented below, the figures, pertaining to the medically indigent load, consist only of those persons classified as medically indigent when requesting medical services. Hence their costs are depicted on a per case basis rather than on a per capita basis.

The Plan has operated very smoothly in this past year. The relief load and the claims for relief load are attributed in large measure to the 1950 figures. The cost per capita of relief load has increased from $1.50 per year in 1950 to $1.83 per year in 1951. The decline in the relief load is attributed in large measure to the high level of employment in northern New Jersey.

Medical care of the indigent and medically indigent under a Plan like the City of Newark Plan meets with the hearty approval of patients, physicians and governmental agencies. The standard of medical care is higher and the costs to the government are less than under other systems. The greatest financial saving is due to the fact that under such a Plan, many people are cared for at home and fewer are hospitalized.

INDIGENT (RELIEF) PERSONS Year	1945	1946*	1947	1948	1949	1950	1951
Mean number of persons on welfare rolls during year	1719	2155	2995	4274	7986	8704	4977
Value of approved services	$2,607.50	$4,971.00	$7,823.00	$8,589.50	$12,046.00	$13,092.00	$9,105.00
Cost per-capita of relief load							
per year	1.51	2.30	2.61	2.00	1.51	1.50	1.83
per month	0.126	0.191	0.217	0.167	0.126	0.125	0.152
MEDICALLY INDIGENT CASES †							
Number of cases during year	1575	2950	2734	3283	4155	4446	3450
Value of approved services	$3,659.50	$9,556.50	$10,633.50	$12,775.50	$15,119.50	$15,298.50	$13,705.50
Cost per case							
per year	2.32	3.23	3.89	3.89	3.639	3.441	3.972
per month	0.193	0.269	0.324	0.324	0.303	0.287	0.331

* In April 1946 fees payable to physicians were increased from $2.00 per day visit and $3.00 per night visit to $3.00 per day and $5.00 per night visit.

† The word "case" means family as distinguished from "persons" referred to under report on indigent.

MEDICAL-SURGICAL PLAN OF NEW JERSEY
THE BOARD OF TRUSTEES

The period, April 1, 1951, to April 1, 1952, has been one of continued growth and substantial progress in the development of Medical-Surgical Plan of New Jersey.

Below is a summary of the annual growth and progress of the Plan by calendar year periods, since its inception in 1942.

The major characteristics are:

1. Progressive growth in the number of persons enrolled.
2. Impressive decrease in the ratio of administrative costs from 51.1 per cent in 1942 to 10.9 per cent of subscription income in 1951.

Year Ending December 31	Earned Subscription Income	Claims Incurred	Claims Incurred (% of Income)	Operating Cost (% of Income)	Persons Enrolled End of Period
1942	$ 11,148.78	$ 5,395.50	48.4	51.1	4,131
1943	74,498.47	49,562.50	66.5	23.9	16,015
1944	187,708.74	135,605.75	72.2	18.9	30,427
1945	326,530.37	208,288.36	63.7	17.5	49,441
1946	540,227.83	370,576.10	68.6	16.8	88,088
1947	947,945.57	681,922.85	72.0	17.1	143,700
1948	1,524,814.76	1,203,651.50	79.0	15.0	236,604
1949	2,545,518.33	1,979,542.90	77.8	13.8	353,827
1950	5,252,060.16	4,278,098.89	81.5	12.9	499,882
1951	8,031,305.47	6,527,374.64	81.3	10.9	669,906

3. Increase in the proportion of income devoted to payments for medical and surgical care from 48.4 per cent of income in 1942 to 81.3 per cent in 1951.

Apart from the remarkable increase in Plan enrollment, and the equally encouraging decrease in the Plan's operating expense, some of the outstanding achievements of the Plan during the past year have been:

1. Inauguration of new forms for reporting claims for eligible professional services.
2. Improved procedure for the processing and payment of such claims.
3. Provision of a *Participating Physician's Certificate* in the form of an office plaque, to each Participating Physician.
4. Increase in the number of Participating Physicians from 4700 a year ago, to 5050 as of March 15, 1952.
5. Preparation of a new *Schedule of Payments* based upon recommendations made by representatives of each of the 21 professional groups named below,* during the course of a long series of conferences on a state-wide basis beginning May 1950.
6. Distribution of a *Manual for Participating Physicians,* including the new Schedule of Payments, Code of Regulations, Forms and Procedures, the History and By-Laws of the Plan, and the statute governing the Plan.
7. Completion of plans for mailing a notice to the subscriber of each Plan payment made to a physician on his account.
8. Establishment of new, or reactivation of existing Advisory Committees to Medical-Surgical Plan as liaison agencies between the Plan and the profession in each of the twenty-one counties of the state.

* The conferring groups were: Society of Surgeons of New Jersey; New Jersey Obstetrical and Gynecological Society; New Jersey Orthopaedic Society; Regional Committee on Trauma of the American College of Surgeons; Eye, Ear, Nose and Throat Section of The Medical Society of New Jersey; Urology Section of The Medical Society of New Jersey; Neurosurgery Committee of Essex County Medical Society; Plastic Surgery Committee of Essex County Medical Society; New Jersey Proctologic Society; New Jersey Society of Anesthesiologists; New Jersey Gastro-Enterological Association; New Jersey Diabetes Association; New Jersey Allergy Society; New Jersey Section, American Academy of Pediatrics; New Jersey Rheumatism Association; Section on Internal Medicine of The Medical Society of New Jersey; New Jersey Heart Association; Northern New Jersey Dermatologic Society; Chest Diseases Section of The Medical Society of New Jersey; New Jersey Academy of General Practice, and the New Jersey Neuropsychiatric Association.

EVOLUTION OF MEDICAL-SURGICAL PLAN

Medical-Surgical Plan, and similar Plans elsewhere, represent the positive and constructive program of the medical profession to solve the basic problems of medical economics—to meet the demands for the distribution of medical care—which in recent years have given rise to the threat of governmental intervention and control of medical practice.

Medical-Surgical Plan has met with a most impressive response in the first decade of its existence. Today, *one out of every seven people in New Jersey is enrolled in the Plan.* This growth, remarkable as it is, must be accepted only as a beginning and as a challenge to greater effort on the part of the profession to achieve its purpose—the extension of the benefits of this Plan to the entire population of New Jersey.

As was stated in the Plan's Annual Report to the Medical Society of New Jersey in 1951:

"Medical-Surgical Plan, like its sister Plans, in the Blue Shield movement, is a dynamic social enterprise. It represents a partnership of employers, workers, farmers, commercial and professional people—together with the medical profession—dedicated to the proposition that the elementary need of the people for medical security can be met by voluntary methods—within the traditional framework of American medicine. Our basic problem is to provide the broadest possible scope of service to the subscribers while safeguarding the legitimate rights and interest of the participating physicians."

Medical-Surgical Plan, in common with most other Blue Shield Plans, has one elementary vital feature that distinguishes it from all other insurance programs offered and guided by agencies other than the medical profession namely, the *service principle.*

The service principle involves an agreement between the Plan and the Participating Physician whereby the physician agrees to accept

the Plan's payment for any eligible service as payment in full, provided the income of the subscriber is within a specified "income limit" for "service benefits".

The physicians who pioneered the Blue Shield movement recognized that merely to promote and sell indemnity programs was no justification for the entry of units of organized medicine into the field of prepaid sickness insurance. Such programs cannot fully meet the public need. Therefore, the conviction became established that a service plan was, and is, the only plan that has a chance of obviating the demand for socialized medicine.

Perhaps most important of all: a service plan is the only type of prepayment that offers every physician an opportunity to participate concretely and consciously, in solving the major medical-social problem of our day. Consequently, a service plan is the one plan that builds a tangible solidarity among physicians in demonstrating the ability of the profession to meet its traditional basic responsibility to the public.

The Plan is proud to be able to state that, as Participating Physicians, approximately 90 per cent of the fully licensed physicians in New Jersey are making an unselfish contribution to the welfare of the people and of the medical profession. The Plan wants its Participating Physicians to know that their cooperation is deeply appreciated. The Trustees of Medical-Surgical Plan regard every Participating Physician as a co-worker in this forward looking enterprise, and are pleased to receive constructive suggestions and advice from him.

PHYSICIAN RELATIONS PROGRAM

As proposed in the Plan's last Annual Report to The Medical Society of New Jersey, the Plan has developed an extensive program of physician relations during the past year.

Some of the features of this program are:

1. A "Medical Director's Letter to Participating Physicians" in which problems and developments of direct and immediate interest to each physician are presented as they arise.
2. The use of the Plan's page in "The JOURNAL of The Medical Society of New Jersey" to publicize announcements of general interest to the profession.
3. Distribution of the "Participating Physician's Certificate (plaque)" and the *Manual for Participating Physicians*.
4. Conferences on the Schedule of Payments with liaison committees representing the various professional groups.
5. Conferences on a regional and local basis with the county medical society advisory committees, on major problems confronting the Plan with respect to proposed contract changes.
6. Conferences with The Medical Society of New Jersey, through the medium of the "Permanent Committee on Medical-Surgical Plan" and by regular reports to the Board of Trustees of the Society.
7. Participation by representatives of the Plan in the programs of regular meetings of County Medical Societies, by invitation.
8. Presentation of a Plan exhibit at the Annual Meeting of The Medical Society of New Jersey.

COMMENT

Through all these, and other media to be developed in the future, the Plan hopes to keep the members of the profession fully informed of the progress made, and the problems confronting and opportunities offered to Medical-Surgical Plan. Only by such means may the profession be enabled to play its indispensable part in guiding the activities and fulfilling the mission of Medical-Surgical Plan.

The Trustees of Medical-Surgical Plan take this opportunity to express their gratitude to Hospital Service Plan of New Jersey for the continued services of the highest order rendered by Hospital Service Plan under the terms of the joint operations contract existing between the two Plans—and especially for the fine accomplishments of Hospital Service Plan in building the enrollment of Medical-Surgical Plan.

The Trustees of Medical-Surgical Plan of New Jersey wish to express to the officers and members of The Medical Society of New Jersey, and to each Participating Physician, their deep appreciation of the continued support and cooperation which has been given to them so generously in their joint effort in the public interest.

STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

E. S. HALLINGER, M.D., Secretary, Trenton

During the period of January to December, 1951, the Board examined sixty-nine applicants for a license to practice medicine and surgery. Four of the applicants were graduates of osteopathic colleges.

The Board also examined nine applicants for a license to practice chiropody.

TABLE I

SHOWING NUMBER OF CANDIDATES FOR THE 1951 EXAMINATIONS, CLASSIFIED AS GRADUATES OF MEDICAL COLLEGES IN THE UNTED STATES AND FOREIGN COUNTRIES

	Total Examined	Passed
MEDICAL		
United States		
Graduates of Medical Schools	48	45
Graduates of Osteopathic School	4	2
Great Britain	1	1
Italy	6	
Switzerland	4	1
Germany	3	2
China	1	1
France	1	1
Greece	1	1
Total Medical	69	54
CHIROPODY		
United States	9	7
	78	61

All candidates were citizens of the United States.

Two hundred and seventy-five licenses were issued to applicants for endorsement of a license from another state, or a diploma from the National Board of Medical Examiners, who presented credentials to prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined.

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals in this country and abroad before a license was issued.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates in the state now in practice is increasing or decreasing.

TABLE II

SHOWING LICENTIATES BY ENDORSEMENT CLASSIFIED AS GRADUATES OF COLLEGES IN THE UNITED STATES AND FOREIGN COUNTRIES

Countries	Total
United States	259
Great Britain	2
Austria	5
Switzerland	2
Italy	1
Czechoslovakia	2
Germany	2
France	1
Lithuania	1
	275

TABLE III

SHOWING NUMBER OF PHYSICIANS AND SURGEONS, OSTEOPATHS AND CHIROPODISTS ENDORSED TO OTHER STATES, THE NUMBER OF LICENTIATES OF WHOSE DEATH THE BOARD RECEIVED A REPORT AND THE NUMBER OF LICENSES REVOKED

Physicians—Endorsed to Other States	53
Osteopaths—Endorsed to Other States	4
Chiropodists—Endorsed to Other States	1
Midwifery—Licenses Revoked	1
Physicians—Deceased	65
Osteopaths—Deceased	1
	125

Annual registration would give the Board accurate information relative to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity.

The laws governing the practice of chiropody and midwifery provide for an annual registration and our records show the same number of chiropodists registered on November 1, 1951, as on November 1, 1950, and a decrease of thirteen midwives for the same period.

ENFORCEMENT

Following is a brief report of the Board's activities in enforcing the laws which they administer:

COURT CASES—VIOLATION OF MEDICAL, ETC., LAWS	
Convicted, Pleaded Guilty or Settled	40
Pending in the Courts	20
Cases Lost	2
	62

HEARINGS BEFORE BOARD	
Medical—Complaint Dismissed	1
Chiropractic—Complaint Dismissed	1
Midwifery—Licenses Revoked	1
	3

TYPE OF CASES INVESTIGATED	No. Investigated
Druggists practicing medicine	18
Prescribing herbs and drugs	14
Unlicensed medical doctors	39
Chiropodists violating advertisement regulations	12
Practicing chiropody without a license	11
Chiropractors exceeding license	4
Unlicensed chiropractors	71
Osteopaths exceeding license	2
Unlicensed osteopaths	1
Naturopaths	5
Physiotherapists	19
Electrotherapists	7
Massage	8
Laboratory Technicians practicing medicine	2
Mental healing	5
Optometrists practicing medicine without a license	1
Unlicensed medical school	1
Medical revocation	1
Chiropractic revocation	1
Midwifery revocation	2
Miscellaneous	15
	239

Investigations and inspections made	239
Visits made and treatments received in making investigations and inspections	1000
Average number of visits per investigation	4.1

COUNTY SOCIETIES

ATLANTIC

ANTHONY G. MERENDINO, M.D., President, Atlantic City

At the beginning of my term as President of the Society, I indicated that a successful administration depended chiefly upon the cooperation rendered by the various committees and the membership. This cooperation has been offered to me to the fullest extent. I am grateful and deeply appreciative to the chairmen and their committees and the membership as a whole. At no time could I find support lacking.

The past year has been studded with an outstanding array of speakers, namely:

SEPTEMBER 14, 1951: Richard L. Masland, M.D., Professor of Clinical Neurology, Bowman-Gray School of Medicine, Winston Salem, N. C. Subject: Clinical Diagnoses of Neurologic Disorders, with Manifestations Resembling Visceral Disease.

OCTOBER 12, 1951: Mario A. Castallo, M.D., Associate Professor of Obstetrics, Jefferson Medical College, Philadelphia. Subject: Recannulization of the Fallopian Tubes.

NOVEMBER 9, 1951: (1) J. Gershon Cohen, M.D., Ass't. Professor of Radiology, University of Pennsylvania, Graduate School of Medicine. (2) Helen Ingleby, B.S. Subject: Breast Malignancy.

DECEMBER 14, 1951: Mr. Leon A. Hamilton, Counsel for the Provident Mutual Life Insurance Company of Philadelphia; and Mr. Theodore Widing, Past-Chairman of the "Million Dollar Roundtable". Subject: Death and Taxes—The Doctors' Dilemma.

JANUARY 11, 1952: Thomas M. McMillan, M.D., Professor of Clinical Cardiology, Graduate School of Medicine, University of Pennsylvania. Subject: Newer Ideas in the Treatment of Cardiac Arrythmia.

FEBRUARY 8, 1952: Priscilla White, M.D., Co-Author of "Diabetes Mellitus". Subject: The Pre- and Postoperative Treatment of the Diabetic.

MARCH 14, 1952: Burgess Gordon, M.D., President of Women's Medical College of Philadelphia. Subject: Recent Advances in the Management of Chronic Pulmonary Diseases.

APRIL 11, 1952: Preston A. Wade, M.D., Professor of Clinical Surgery, New York Medical College. Subject: Do's and Don't's of Fracture Treatment.

Esteem and honor have been reflected upon this Society during the past year by one of our members, namely, Dr. David B. Allman. He is one of the Trustees of the American Medical Association. Despite the fact that his new duty calls for service away from home, he has still found time to attend all of our meetings. I wish to express my sincerest thanks to him for the guidance that he has so graciously offered me when problems have arisen.

One of the most trying tasks in the Society is the office of secretary. Dr. Louis Rosenberg has fulfilled this duty to the fullest extent and at this time I wish to extend to him my sincerest thanks and appreciation for the support and guidance that he has rendered.

Without an impressive list of speakers the Medical Society would not derive its fullest benefit. Dr. Clarence B. Whims, as chairman of the program committee deserves the highest commendation for having secured the speakers for the past year. I am cognizant of the tremendous amount of time and effort entailed and the burden that has been removed from my shoulders.

Our *Bulletin* during this past year has become conspicuous locally and out of our state. To Dr. Samuel Diskan and his *Bulletin* staff, I extend my deepest appreciation for his having accepted the position of editor and for having done such a noteworthy job.

A position that necessitates traveling out of town on many occasions cannot pass by unnoticed. Dr. Baxter Timberlake as chairman of the welfare committee has expended much valuable time and effort keeping our Society in line with the decisions rendered on a state level. I wish to express my gratitude for his untiring efforts.

Dr. John Holland as chairman of the public relations committee has performed remarkable and outstanding work. Despite the many adverse problems that have arisen in setting up the Medical Emergency Service, through his efforts we now have a plan that has met favorably with the membership of our Society.

Our Society is now enrolled as a group with the Hospital Plan of New Jersey and we are deeply indebted to Dr. James Gleason for having undertaken the tremendous amount of work involved in setting up the group and collecting the premiums for the Plan. He and his committee are still very actively engaged in important issues that are arising in the Medical-Surgical Plan of New Jersey.

The Plan for examinations pertaining to temporary disability benefits has been very capably undertaken by our chairman, Dr. Charles Saseen. The State has described our Plan as a model for other County Societies in New Jersey.

Atlantic County physicians are extremely fortunate in that graduate education has been brought to our very door step. Dr. Hilton S. Read and his staff have worked diligently in the maintenance of a graduate educational program. The least we can do in thanking him for his efforts, is to attend the meetings.

The Woman's Auxiliary to this Society under the very capable leadership of their president, Mrs. Matthew Molitch, have been of great assistance to us. I take this opportunity of thanking her and her committees for a fine job.

It is with sorrow and regret that I report the demise of seven of our members: Dr. Isaac Shenfeld, Dr. Filbert Corson, Dr. Goldman, Dr. Richard Fowler, Dr. Norman Bassett, Dr. Samuel Gorson, and Dr. Edward Guion. We shall miss them immensely.

In review, as I look back on this year, I feel that this Society has accomplished much and I will always cherish the privilege of having been its president. I feel sure that my successor will carry on to attain greater heights. I therefore pledge my wholehearted support to the in-coming administration.

BERGEN

Edward V. Sexton, M.D., President, Teaneck

The year 1951-52 has been relatively quiet with the definite subsidence of aggressive attempts to force State Medicine through the front door and the sudden discovery by Oscar Ewing that he was never in favor of it after all.

However, the emergency call problem has continued to be one of our major concerns. Dr. Knowles and his Public Relations Committee have done much to iron out this situation. Mr. Randall Norris, Public Relations Coun-

sellor to the Bergen County Medical Society has helped with the periodic release of press notices relating to the various phases of our program and activities. A third large scale undertaking has been establishment of a liaison committee with representation in various communities to keep in touch with each Town Council and its individual administrative heads to track down complaints at their source. Since there are some seventy municipalities within the county, this committee has proved somewhat unwieldy and will probably require streamlining in the future—though the idea itself is a good one.

In keeping with the practice of participating in the annual National Health Week it was again decided that we would cooperate in a way more appropriate to our individual circumstances. At the invitation of the *Bergen Evening Record,* the only daily newspaper in this county, it was decided to sponsor a special Medical Society issue of this paper. A similar undertaking was handled with great satisfaction in 1938 and it is hoped that much of our public relations story may be put across in this fashion to more people than could be reached by any type of local demonstration or exhibit. This project is under the joint supervision of the Public Relations and Public Welfare Committees under Drs. Knowles and Wolfe respectively.

The work of the special Blood Bank Committee which had been progressing satisfactorily under Dr. Anderson, had to be deferred pending the cessation of the Korean "police action" and a lessening in the Red Cross demands for immediate all-out blood donations.

The Scientific Committee has continued its good work of the past years in furnishing scientific programs of outstanding quality to follow each of the Society's regular business meetings. Two of these programs, we believe, merit special mention. The first concerned itself with "The Problem Drinker" and brought excellent speakers from The Alcoholic Foundation, Malverne Institute, Eastman Kodak Company and the National Research Council. The other was in cooperation with the Passaic County Medical Society at which several of the pioneers in the development of the new drug therapy of tuberculosis presented resumes of their work to date.

There is a plan, at present embryonic in form, to study the possibilities of consolidating the scientific programs of Passaic and Bergen counties with the membership divided into "sections" for more adequate coverage of subjects of more interest to more people.

BURLINGTON

T. Bruce Dickson, M.D., President, Riverton

The Burlington County Medical Society in 1951-52 had a very busy year with some sadness intermixed. Monthly meetings were held in Riverton, N. J., on the second Thursday of each month.

The Program Committee under the able leadership of Dr. William Betsch presented the Society with the following interesting series of lectures:

September: Acute Pericarditis—Dr. Joseph V. Vander Veer
October: Functional Disorders of Gastro-Intestinal Tract—Dr. Alexander Rush
November: Civilian Defense
December: Common Lesions and the Cancer Problem—Dr. W. W. Lindemuth
January: Pediatric Neurosurgery—Dr. Eugene B. Spitz
February: Cerebral Palsy—Dr. Temple Fay
March: ACTH and TRYPTAR (Movie) through courtesy of Armour Company
April: "Home Talent"
May: Annual Meeting with Woman's Auxiliary

The November meeting on Civilian Defense was very instructive. Invitations were extended to the dentists, osteopaths and nurses in the county.

Mr. Arthur W. Lewis, former New Jersey Senator, discussed the world situation as related to the United States and indicated the need for Civilian Defense. Mr. Thomas Dignan, Deputy Director of Civilian Defense of the state of New Jersey, described the organization on the state level. Mr. Budd Marter, Defense Director of the Pines Area, spoke on the organization in his area which includes Burlington County. Dr. Paul Sparks discussed the medical arrangements made in Burlington County, and Mr. Robert Grover did the same in regard to Mt. Holly. Dr. R. Winfield Betts, medical director for the Pines Area, stressed

the urgent need for civilian defense and asked for everyone's cooperation. A discussion period followed in which many questions were asked, and they were all answered to everyone's satisfaction.

The April session, the Burlington County Society's traditional "Home Talent" meeting, is always interesting and informative because the cases are those seen every day but which have some unusual aspect; also some very unusual cases are presented.

In 1951, Burlington County had sixty-six members. At this date the number has been increased to seventy-one. With the population increasing in this county at the present rate, more doctors will be needed to give adequate coverage.

The Public Health Committee, during the week of November 11, held a Diabetes Detection Drive, and quite a few cases were discovered. Much publicity was given this worthwhile cause.

It is with sadness that we mention the untimely death of Dr. W. Edward Torrey on December 29, 1951. He was fatally injured in an automobile accident in front of the Burlington County Hospital, Mt. Holly, on December 26, 1951. Dr. Torrey was an outstanding obstetrician and enjoyed a reputation which few men do at his age. As a result of this tragedy, the Burlington County Medical Society has gone on record of favoring a good, effective law in regard to compulsory public liability insurance.

This year the Society has taken on a new venture by sponsoring a scholarship for a nurses' training program to an eligible resident of Burlington County. Recipient of this scholarship is to be chosen on a competitive basis by a committee of the County Society. This is a modest beginning, but as time goes along it is hoped that more than one nurse will be in training under a scholarship from this Society.

In February the Woman's Auxiliary entertained the members of the Burlington County Medical Society at a dinner which was followed by dancing. It was well attended, and the members look forward to this yearly event.

In a brief summary such as this, it is difficult to include all the activities of all members and committees. However, the fine work which everyone has done is greatly appreciated. The President extends to all the members his sincere appreciation of their cooperation.

CAMDEN

Walter A. Crist, M.D., President, West Collingswood

Monthly meetings have been held throughout the year. The scientific programs have been marked by outstanding speakers who carried a variety of medical and surgical subjects. Our historian has compiled a photographic album of each member of the Society. This, together with the professional history of each member will be of inestimable value.

Our Public Relations chairman has established "emergency call" services in various communities. This is working exceptionally well so that some doctor is always on call in these communities.

A successful membership drive was made which resulted in obtaining twenty-three new members. Four members were lost by death, two were dropped for non-payment of dues, one resignation and one transfer.

My fellow officers, chairmen and members of the various committees have been very active and efficient—to them I owe a successful year.

CUMBERLAND

Edwin C. Greene, M.D., President, Bridgeton

Regular meetings of the Cumberland County Medical Society were held in June, October and December of 1951, and in February and April of 1952. The attendance was only slightly better than the usual 50 per cent of the membership.

One new member, Dr. Peter E. Penico of Millville, was added by transfer. Loss of a

distinguished member was suffered by the death of Dr. Ray Simpkins, Bridgeton, a past president and a member-emeritus.

A revision of the constitution and by-laws to provide for a county judicial committee was adopted and five members were elected to that committee.

Delegates from the Cumberland County Medical Society had perfect attendance at the annual meeting of The Medical Society of New Jersey.

After repeated discussion, approval was finally given to the organization of a Woman's Auxiliary to the Cumberland County Medical Society. A representative group of wives met with Mrs. Thomas H. McGlade, president of the state auxiliary, and accomplished that organization.

The graduate education committee (Chairman, Dr. Sherman Garrison, Jr.) arranged for an excellent series of six lectures.

Due to the enthusiastic efforts of our program chairman, Dr. Norman Henry, we have had the privilege of hearing several able speakers during our scientific sessions: Dr. George B. Rosemond of Temple University on "Treatment of burns"; Dr. Henry S. Bourland of Jefferson Medical College on "Precancerous lesions of the anus, rectum and colon"; Dr. Charles Shivers of the University of Pennsylvania on "Calculi of the urinary tract"; and Dr. J. Gershon-Cohen of the Graduate School of the University of Pennsylvania on "The present day trend of atomic medicine".

ESSEX

Kenneth E. Gardner, M.D., President, Bloomfield

During the past year the Essex County Medical Society endeavored to interest more of its members in the affairs of their society and to emphasize the importance of good public relations between the medical profession and the general public. The regular monthly meetings were sponsored by various physician groups and hospital staffs throughout the county with each group arranging one program. This produced an excellent and interesting variety of economic and scientific subjects. Each meeting was held in the community of the sponsoring group and provided an opportunity for many more members to attend the regular monthly meetings. All of the meetings were well attended and were followed by a collation which further provided the opportunity to renew acquaintances with other members from various parts of the county.

The Judicial Committee was organized during the year and in the interest of good public relations has encouraged any person who feels that he has a just complaint against any physician in the county to appear before the committee. This was a new venture in the field of public relations but it provided a valuable source of information about the sentiments of the public toward physicians. Impartial evaluation of the cases or complaints presented was a feature of the project. Although most complaints followed a similar pattern, the majority of the problems dealt with misunderstandings concerning fees and the need for more explicit information from the physician to the patient concerning his condition. If any conclusions can be drawn at this time, they are that the physician should thoroughly explain to the patient his condition and the reasons for additional diagnostic and therapeutic procedures, and also the cost of these services *before* they are rendered.

The Essex County Blood Bank has continued its fine public service under the administration of the Essex County Medical Society in cooperation with the ten local Red Cross Chapters and the Essex County Board of Chosen Freeholders. A fourth group, comprised of the hospitals of Essex County, is also essential to the smooth operation of the County Blood Bank Program. At present, hospital administrators are cooperating with the program and are studying a plan to organize such a group and to establish uniformity in service charges and blood replacement among the various hospitals throughout the county. This Blood Bank has dispensed more than 40,000 pints of blood to the residents of Essex County since 1947, and many lives have been saved and prolonged periods of disability have been reduced by this humanitarian effort. More than 30,000 pints of blood a year are now used in Essex County of which one-half is supplied by the Essex County Blood Bank and the remainder from the private hospital blood banks. The ultimate goal, however, is to collect and distribute 50,000 pints of blood a year through the Essex County Blood Bank.

With the ever widening problems of health

on a community basis, the practice of medicine and the role of the social, health and welfare agencies in Essex County have been further discussed. Several hundred agencies in Essex County operate on a municipal, county, state or national basis. Most of these are interested in some phase of health and the County Society is frequently asked to appoint medical advisers. Due to the great variety of organizations now interested in health problems, a plan is being discussed whereby all the agencies could be represented on a county-wide Council with the County Medical Society acting in an advisory capacity on medical or health problems, when requested through the County-wide Council rather than by each organization separately.

The Speakers' Bureau has presented an increasing number of courses at the Adult Schools throughout the county on "Recent Advances in Medicine". A similar series for students has also been inaugurated at Rutgers University. Both have been well received.

Short articles on current medical subjects of general interest to the physicians now appear each month in the *Bulletin*. These are prepared by the various committees and have provided a brief but pertinent discussion of timely medical topics.

We have continued to enjoy good public relations with the members of the press, radio and television, and the close cooperation and support of our own Woman's Auxiliary.

It is not possible to mention all of the activities which have occurred within the society during the past year. The willingness of so many members to serve on committees or in other capacities has produced an excellent spirit of cooperation within the society and indicates the continued success of the society's many activities for the coming year.

GLOUCESTER

Anthony J. DiMarino, M.D., President, Paulsboro

No report of the activities of the Gloucester County Medical Society would be complete without paying due tribute to that pillar of our organization, Doctor Chester I. Ulmer, who acted as chairman of the Program Committee. The eminence of the speakers and scientific interest of the subjects here to follow are evidence of the zeal which characterized their activities:

September—"Diagnosis and Malignancies of the Esophagus and Stomach", Dr. J. Edward Berk.
November—"Recent Advances in Cardiovascular Diseases", Dr. Charles C. Wolferth.
December—"Psychiatric Problems in General Practice of Medicine", Dr. Edward T. Auer, Jr.
January—"Treatment of Peptic Ulcer and Outstanding Research on this Problem", Dr. John T. Eads.
February—"Do's and Don't's of Office Urology", Dr. Francis G. Harrison.
March—"Cancer and Allied Diseases of the Breast", Dr. Fred G. Medinger.
April—"Present Concepts of Antibiotic Therapy", Dr. Harrison Fitzgerald Flippin.

These meetings were always well attended and adequately supported by members. The spirit and animated discussions of both the scientific and business phase were always a promise that the succeeding month would insure a good representation.

In October we made the usual departure from our regular monthly program and spent the evening in an enjoyable and festive dinner, during which we were privileged to pay host to Doctor Sigurd W. Johnsen, President of The Medical Society of New Jersey, in company with other distinguished lay citizens of our community. We have always felt that the socio-professional impact of this affair reflects itself to the mutual benefit and better understanding of the doctors, in this area, with their neighbors.

Our colorful *Bulletin,* edited single-handed by Dr. Clarence A. Bowersox, reaches each member monthly, containing in addition to the announcements of medical portent, the usual literary gems and trite witticisms, which make it an eagerly awaited, and a welcome bit of correspondence.

It was indeed inspiring to witness the ardor, enthusiasm and cooperation which existed between the Committees, their respective chairmen, and the entire membership. It would be difficult to enumerate to any degree of detail all of the activities of these groups, but I wish to take this opportunity of thanking them and the officers for the splendid support and interest they have displayed in the affairs of the Society and for the privilege shown in allowing me to serve them during the past year.

HUDSON

William J. Gleeson, M.D., President, Jersey City

Of the usual eight regular monthly meetings which begin in October, seven—all well attended—have taken place. Guest speakers who presented medical subjects of current appeal included Drs. Charles P. Bailey and Robert D. Dripps of Philadelphia; and Drs. William J. Grace, Homer W. Smith, Morris Ziff, and Henry Dolger, all of New York. Our meeting on February 5, 1952, marked the beginning of what promises to be a close relationship with the Heart Association of Hudson County. On that date, through Dr. Nathan Frank, it was our privilege to present Dr. Janet S. Baldwin of New York, one of the foremost authorities in her field, on "Newer Concepts in the Diagnosis and Management of Heart Disease in Infancy and Childhood". An hour of relaxation over a repast, light but delectable, followed the meetings and provided opportunity for us to fraternize with colleagues.

Committee activities, initiated with zeal, are following through to fruitful conclusion. Albeit space does not permit a detailed account of individual committee projects, we believe that the following committees, with their chairmen, are deserving of mention: Cancer (Dr. John B. Faison), Constitution and By-Laws (Dr. Andrew C. Ruoff), Diabetes (Dr. Lewis Schwartz), Joint Professional Relations (Dr. John L. Varriano), Membership (Dr. J. Lawrence Evans), Physician Resources (Dr. Joseph F. Londrigan), Postgraduate Medical Education (Dr. George Ginsberg), Publication (Dr. Raymond S. Driscoll—Dr. Arthur P. Trewhella), Public Health (Dr. John J. Mackin), Public Relations (Dr. Vincent P. Butler), School (Dr. Charles P. DeFuccio), Conservation of Sight and Hearing (Dr. Louis A. Amdur), Advisers to Auxiliary (Dr. Morris Bresev), Board of Censors (Dr. Abraham E. Jaffin), and Executive — over which, as president, it has been my pleasant duty to preside.

From November 11 to 17, 1951, the Society sponsored its Annual Diabetes Detection Drive through the *Diabetes Committee*. During this period, diabetes detection centers were in operation in all local hospitals for the convenience of the public, without charge. The Society has collaborated closely with the local chapter of the American Cancer Society through the *Cancer Committee*. Members of this committee, with considerable inconvenience to themselves, are filling numerous speaking engagements throughout the county, proving themselves ambassadors of good-will, as reports from the groups addressed testify. During the year, the *Committee for Postgraduate Medical Education*, perennially one of the Society's most diligent groups, collaborated with the Jersey City Medical Center in arranging an ambitious program. This year's portion of the program consisted of a course of five illustrated lectures by Dr. Carroll M. Leevy and Dr. Angelo M. Gnassi covering current concepts in the "Diagnosis and Treatment of Liver Disease". Considered to be the best of any graduate course yet sponsored by the Society, the present series will terminate on March 28. The closing year witnessed a revision of our by-laws and the distribution of a new issue of the *Constitution and By-Laws*, an undertaking of considerable magnitude, shared, of course, by the Executive Committee. The *Publication Committee* continued to direct publication of a self-sustaining monthly *Bulletin* which serves to announce meetings, as well as to chronicle our activities and interests. Also, our *Board of Censors* devoted much time in patient analysis and adjudication of the cases referred for this purpose. To our credit, such cases were few in number.

Prominent among civic projects in which our Society took part, was the *Jersey City Community Fund Campaign* under the enthusiastic leadership of Dr. Conrad M. Bahnson.

As a distinction of the present administrative year, Hudson County Medical Society takes pleasure in again stepping to the fore in State Society activities to present one of the most distinguished members in its history for nomination to the office of second vice-president of The Medical Society of New Jersey—Dr. Vincent P. Butler of Jersey City.

During the year, Honorary Membership was conferred on Dr. Charles H. Finke, Dr. George W. Muttart, and Dr. Frederic J. Quigley, all of Jersey City, and Dr. Alfred A. Mutter of Arlington.

Since May 1951, our organization mourned the death of seven active members: Dr. Lucius F. Donohoe of Bayonne, past-president of this Society and of The Medical Society of New Jersey, on May 23, 1951; Dr. Thomas A. Higgins of Jersey City on May 28, 1951; Dr. Malvin Finkelstein of Jersey City on June 20,

1951; Dr. Alvin E. Kuhlmann of Union City on September 13, 1951; Dr. Irwin Markowitz of Jersey City on October 20, 1951; Dr. Morris Frank of Bayonne on January 1, 1952; and Dr. Julius Heilbrunn of Jersey City on March 4, 1952.

This passing administrative year marked the establishment by this county of a living memorial to a deceased member, past-president of this Society and of the State Society, and past vice-president of the American Medical Association, the late Dr. James Francis Norton of Jersey City. Since the tenets and objectives of The James F. Norton Memorial Fund have been fully explained through other media, mere mention of this unusual posthumous honor is considered sufficient.

Not intending wholly to neglect the social aspect of our being, two events were planned to relieve the tension of a work-crowded schedule. On November 13, 1951, our Second Annual Hobby Show at Murdoch Hall, arranged by the incomparable Dr. and Mrs. Louis L. Perkel, was presented under joint sponsorship with our Auxiliary. Mrs. Morris Bresev, president of the Auxiliary, shared the responsibility with her characteristic grace and competence. Our hobbies, ranging from the usual to the unique and to the bizarre, arrested the eye, the ear, and even the palate of the beholder—which included countless nurses, interns and residents, as well as ourselves. Sharing its pleasure again on November 28, 1951, members of the Society and their ladies attended a benefit performance of "Two on the Aisle" in New York, being indebted for that evening of enjoyment to Mrs. Albert A. Lepis and Mrs. Bresev.

As this report is being prepared, but two major objectives remain on the Society agenda for fulfillment: (1) Group enrollment of our membership in the Hospital Plan of New Jersey (under the leadership of Drs. Campana, Butler and Trewhella), and (2) Solution of the Emergency and Night-Calls problem as it exists in Hudson County. Judging by the progress made to date, we feel justified in assuming that by May 6th, the date of our Annual Meeting, both of these objectives will have been achieved.

Last on our 1951-52 program, but first in the hearts of some of our colleagues, comes the Annual Dinner on May 17, 1952, under the chairmanship of Dr. Harry J. Perlberg, vice-president. Preceding by only a few days the Annual Meeting of The Medical Society of New Jersey, our administrative year will come to a formal close on that date.

In concluding this report, I wish to thank my fellow officers and the members of the Executive Committee—also the chairmen and the members of every committee without exception—as well as each and every member of the Society—believing that all, in some way, have contributed toward making my term of office a pleasant experience and a period upon which I shall look back with warm sentiments of good-will and satisfaction.

HUNTERDON

A. John Bambara, M.D., President, Flemington

The new administration started off by revising the old by-laws and bringing them up to date. A copy was sent to all members and a copy will be given to each new member. The number of meetings was increased from 4 to 6 per year and this year our meetings were highlighted by the presence of Dr. Harrold A. Murray, President-Elect of the State Medical Society, and Mr. Richard I. Nevin, Executive Officer of the State Medical Society.

The graduate lectures conducted and arranged by Dr. Ray Trussell of the Hunterdon Medical Center continued to serve the Society by bringing to the members, men who are experts in their field, for the purpose of bringing the rural physician up to date in medical knowledge.

Although certain facets of the Hunterdon Medical Center were functioning, the actual ground breaking for the building of the Center did not occur until November 1951. Many notables were present at the ceremony as well as a representative of the County Medical Society. This Center will be a boon to the people of the county as well as to the county physicians who in the main are general practitioners.

Adequate medical coverage during weekends was established in the Flemington area. It was impossible to provide such coverage in other communities because most communities had only one available physician and because the distance between areas was too great.

The County Society went on record agree-

ing to cooperate with a chronic disease survey in connection with the Hunterdon Medical Center whenever the survey is to be started.

It also approved of and gave its support toward the establishment of a local public health unit for Hunterdon County.

The Society added two new members to its roster.

The March meeting presented an innovation in that it was essentially a dinner at which the wives and partners of the members were guests. The new officers were elected at that time.

It gives me great pleasure to announce that our Society is 100 per cent paid as far as county and state dues are concerned.

The president wishes to express his gratitude to his fellow officers, committee members and especially to the faithful members who always attend the meetings. And if at any time during the meetings, someone's feelings were hurt, let him be assured that no ill intentions were meant and his forgiveness is begged.

MERCER

Ferdinand K. Engelhart, M.D., President, Trenton

The Mercer County Component Medical Society, under the leadership of its president, Dr. F. K. Engelhart, has endeavored through the year 1951-1952, to promote an improved public relations program.

First step taken toward this objective was accomplished through the appearance before the Society on October 10, 1951, of Mr. H. Russell Brown, representing the Delaware Valley United Fund, who told our members of the advantages of the Fund, its objectives, and urged the members to contribute generously. The success of this effort is attested to in a letter, dated March 11, 1952, received from Mr. Brown.

Trenton and its environs, during the past two years, have witnessed a substantial growth in population because of increased industrial activity in this area, which has resulted in many new families locating within the jurisdiction of the Mercer County Medical Society. Many of these newcomers have been experiencing difficulty in locating a physician in emergencies, and the members of our Society gave consideration to the establishment of a program for the handling of emergency medical calls, and have adopted a system, in cooperation with the local (Trenton) telephone answering services and the Princeton Hospital (which cooperation has been voluntarily offered). The program provides that each telephone exchange and each hospital be provided a list of the names of all Society members, together with addresses, telephone numbers, and hospital affiliations, kept up-to-date at monthly intervals by forwarding these agencies the names of newly-elected members. The program further provides that the agencies are to be notified that the Society recommends that in the event of an emergency call, a physician be contacted to make the call, rather than supplying the caller with the names of one or more physicians, and that the agencies receive reasonable assurance from the physician contacted that he will make the call. The agencies are requested to maintain a list of all such calls together with the facts as to their handling, which list is forwarded to the Secretary of the Society at monthly intervals for the purpose of providing constructive criticism and a method through which we may determine the extent of the problem of emergency calls.

The public was informed of the establishment of the program through a news release, which appeared in the local newspapers.

Grievances between patients and members are being handled through the mechanics provided by the Society's Judicial Committee.

Our Society entertained the members of the Mercer County Pharmaceutical Association at a dinner on February 28, 1952. The speaker was Dr. Iver Griffith, dean of the College of Pharmacy in Philadelphia.

The guest speaker at our Annual Meeting, on November 15, was Mr. Richard I. Nevin, Executive Officer of The Medical Society of New Jersey, who brought greetings to the membership from the officers of the state organization, and presented an interesting and inspiring talk on the challenge with which the medical profession is faced, and the manner in which it is being met.

The New Jersey Department of Labor, Division of Employment Security, in a communication directed to the Mercer County Medical Society, requested that serious and preferred

consideration be given the matter of impartial examinations. President Engelhart appointed a committee to study the situation, whose recommendation was adopted, namely:

That the Bureau is authorized to make contact with the secretary of the Mercer County Medical Society, who is empowered to designate such physician when called upon, from a panel of physicians who have offered to serve as such examiners.

With the cost of living constantly spiraling, our members were very happy to learn their local dues had been reduced for the year 1952.

Through the tireless efforts of the chairman of the Insurance Committee, Dr. John F. Johnson, our members may now avail themselves of the benefits of the Hospital Service Plan of New Jersey (New Jersey Blue Cross) and the Medical-Surgical Plan of New Jersey (Blue Shield).

The Mercer County Component Medical Society, during the year, has taken action on several vital issues, i.e.:

1. Recommending that all the medical services as listed by the Blue Cross be eliminated from their present coverage.

2. We approve changes in the Blue Cross and Blue Shield Plans, as proposed in the report of the Permanent Committee on Medical-Surgical Plan, presented at a meeting of the Trustees of The Medical Society of New Jersey, January 6, 1952.

3. We approve the resolution contained in the Medical Practice Committee's report, under Section "D", "Laboratory Medicine", relating to consent for post-morten examination of the body of a deceased person. This resolution was presented in the State Society Welfare Committee's Report, dated December 2, 1951.

4. We approve the recommendations made by the Public Health Committee that steps be taken to enforce apprehension of contacts under the "State of War Act and Subversive Crimes" which makes it possible to arrest and enforce treatment of prostitutes. (State Society Welfare Committee's Report, dated December 2, 1951).

5. We recommend that the Medical Practice Act be extended to include not only laboratory pathologists, but also the practice of radiology; anesthesiology; physical medicine; physical rehabilitation, and roentgenology.

6. We are opposed to fee splitting in any form, either privately or in association with any insurance plans, and any member found guilty of this breach of ethics by the Judicial Committee, will be dropped from the Society's membership.

This action was taken in the light of a recent proposal offered by the Medical-Surgical Plan of New Jersey.

7. We favor the formation of a consolidated health district within the county.

During the year, five scientific programs were presented by our Program Committee, of which Dr. John A. Kinczel is Chairman:

"The Hemolytic Anemias"
(By Dr. Max Strumia, Director of the Laboratory, Bryn Mawr Hospital, Bryn Mawr, Pennsylvania.)

"The Relation of Life Stress to Organic Disease"
(By Dr. Stewart Wolf, Associate Professor of Medicine, Cornell University Medical College.)

"Hoarseness as a Medical Problem"
(By Dr. Joseph P. Atkins, Professor of Broncho-esophagology, University of Pennsylvania.)

"A Discussion of Several Cases of Maternal Mortality"
(Moderator—Dr. Philip F. Williams, Consulting Surgeon, Presbyterian Hospital, Philadelphia.)

"The Diagnostic and Therapeutic Uses of Radioactive Iodine"
(By Dr. Solomon Silver, Assistant Clinical Professor of Medicine, Columbia University.)

Highly successful "Public Health" and "Diabetes Detection" weeks were held under the chairmanships of Doctors Lester J. Finkle and Nathan Swern, respectively.

Twenty-five new members have been taken into our Society during the past year. Fifteen of our members are serving with the armed forces. Doctors A. Dunbar Hutchinson and Charles H. Mitchell were elected to Emeritus Membership in The Medical Society of New Jersey, and the name of Dr. John H. McCullough has been proposed for election to Emeritus Membership.

Five members have resigned (two to pursue postgraduate work; three have changed their place of residence).

Seven members have been dropped from membership because of non-payment of dues.

We regret to report the loss of two members, who have passed away since our last annual report was made to the State Society, namely: Dr. Theodore V. J. Mitskas, deceased October 2, 1951; and Dr. James A. Murphy, deceased December 5, 1951.

MIDDLESEX

Charles H. Calvin, M.D., President, Perth Amboy

This is the report of the Middlesex County Medical Society.

January—"Coughs in Children"—Daniel C. Baker, M.D., Columbia University.

February—"The Increasing Incidence of Poliomyelitis"—Robert J. Neville, M.D., National Foundation for Infantile Paralysis.

March—"Anticoagulant Therapy in Thrombo-embolism"—D. V. Habif, M.D., Columbia University.

April—"Do's and Don't's of Anticoagulant Therapy"—Stuart Cosgriff, M.D., Columbia University.

May—"Know Your River"—George F. Smith, Johnson and Johnson.

June—"Effect of Establishment of Medical School in New Brunswick on Local Practice"—C. H. Smith, F. M. Clarke, H. Haywood and J. H. Rowland.

October—Tour of E. R. Squibb and Sons Laboratories; address by W. E. Bunney, M.D.

November—"Know Your State Medical Society"—Harrold A. Murray, M.D., President-Elect, and Richard I. Nevin, Executive Officer, The Medical Society of New Jersey.

December—"Medical Education in the United States"—Lewis Webster Jones, president of Rutgers University.

Officers were elected and installed at the dinner meeting in December.

MONMOUTH

J. Berkeley Gordon, M.D., President, Marlboro

In Monmouth County, the past year has been one of continued progress. Membership has increased to a new high of 230 and has shown an increasingly high morale and a continuing spirit of helpful cooperation, friendliness and mutual respect.

A new policy of scheduling our regular monthly meetings in different sections of the county resulted in a considerably increased attendance. Scientific programs dealing with timely and pertinent topics were presented by prominent speakers on the following subjects:

1. "The Treatment of Alcoholism and Its Relation to Alcoholics Annonymous".
2. "Psychiatry in a General Hospital".
3. "Practical Aspects of the Treatment of Diabetes and Its Complications"
4. "Problems in the Diagnosis and Prevention of Virus Respiratory Disease"
5. "Diseases of the Gall Bladder and the Biliary Tract"
6. "Nutritional Factors in Medicine"
7. "Rheumatic Fever"

Taking cognizance of the nation-wide attention being directed to the narcotic problem, we have scheduled a talk on "Drug Addiction in Adolescents" by Dr. Toolan of Bellevue Hospital for our May meeting to be held at the State Hospital at Marlboro.

Once again, it was our privilege to conduct a regular meeting at Fort Monmouth where we were the guests of the medical staff at the Station Hospital.

The second annual dinner-meeting with the Monmouth County Dental Society and the Monmouth-Ocean County Pharmaceutical Society was well attended. This, along with other regular meetings of the Joint Committee on Inter-Professional Relations, in our opinion, contributes a great deal to better understanding and cooperation between the members of the three allied professions.

We have continued our program of "round-the-clock" emergency medical service inaugurated four years ago. Some difficulties in providing coverage has been experienced in a section of the county where the population has increased considerably without a corresponding increase of physicians in the area.

Under the heading of public relations, a very appreciable number of our members have given a considerable amount of time to speak before lay scientific groups about organized medicine and scientific topics. Many of these talks were scheduled by our Speakers Bureau.

Our Blood Bank Committee has continued its efforts to organize units of volunteers to serve as blood donors at a local level to meet the civilian blood needs of the various communities in the county. In addition, we have named one of our members to assist in the assignment of physicians to the Monmouth County Chapter of the American Red Cross in the program of blood procurement for the armed forces.

Radio programs on "Mental Health", "Cardiovascular Disease" and "Cancer" were pre-

sented over radio station WJLK during Public Health Week.

The Public Health subcommittees have maintained excellent liaison with official and voluntary agencies and organizations conducting programs of health education and service for the residents of our county. The members of the respective committees have taken an active part in developing and furthering the projects of the various agencies and organizations. Particularly worthy of praise are the following subcommittees: Cancer Control, Cardiovascular Disease, Diseases of the Chest, Medical Care for the Indigent, Care of the Chronically Ill, Mental Health, Venereal Disease, Crippled Children, and School Physicians.

Our Woman's Auxiliary, while conducting a most commendable program of its own, has also, when called upon, given willing and enthusiastic support to Medical Society projects and endeavors. A joint committee of the Auxiliary and the Society sponsored the Annual Summer Dinner-Dance and the Winter Holiday Dinner-Dance.

This report has only highlighted the activities of our Society—many other committees and a large number of our members have given unsparingly of their time and efforts in the interest of the Society.

Vilhjalmur Stefansson, the noted arctic explorer, remarks in his very significant book, *My Life With the Eskimo,* that the ideal expedition is one which is devoid of adventures, meaning thereby, that most adventures are the result of carelessness, ignorance and poor planning. In a way this is applicable to our year just past—we have had no major adventures or disasters and this, we think, can be ascribed to the devotion, hard work, and spirit of cooperation characteristic of all our members.

MORRIS

C. Archie Crandell, M.D., President, Greystone Park

The Morris County Medical Society in its 136th year has continued active support of the program of The Medical Society of New Jersey and of the American Medical Association.

Dr. Ruth Earp, Chairman of the Program Committee, arranged two meetings on graduate education. The October meeting featured a symposium on peptic ulcer, and the November meeting a symposium on diseases of the biliary tract. The speakers, Dr. Thomas A. Johnson, Dr. Arthur Finkelstein and Dr. Donald Cooper, were from the staff of the Graduate School of Medicine of the University of Pennsylvania. The February meeting was devoted to coronary artery disease and Claude S. Beck, of Western Reserve University, conducted the discussion and showed his film on "Surgery of the Heart". The subject for the March meeting was "Applied Psychosomatic Medicine in General Practice", the speaker being Dr. Keith Fischer of Temple University. The January meeting was informal: cocktails and dinner being served to 120 members and guests at the Spring Brook Country Club.

The present membership of the Society is 166, including seven Emeritus Members. Members in the Service are Drs. Frank L. Bird, Daniel B. Carroll and James E. Ziegler. Twelve new members were elected into the Society, Drs. Anne Hale Dodd, Crawford N. Baganz, Mary Frances Brown, Samuel J. Arnold, Edward C. Kley, Raymond C. Maronpot, Harold J. Muendel, Charles C. Scott, Max W. Flothow, Jr., Dominick J. Huster, Jaroslav J. Lenko and Byron G. Sherman, Jr.

The quarterly *Bulletin* of the Society has continued its regular appearance with timely notice of meetings and announcements of interest to the members. These included announcements of Neuropsychiatry Day at the Veterans Administration Hospital at Lyons in October and of the Third Scientific Session of the New Jersey Heart Association in March.

The committees have all been active, and special thanks are due the chairmen for their excellent work. Along with the increase in membership has come a larger attendance at the meetings, and special thanks are due the Chilcott Laboratory for providing such excellent facilities for our meetings as well as for their generosity in furnishing refreshments, which add so much to the social hour following the scientific sessions. The Executive Committee (Drs. J. H. Harrington, T. R. Failmezger, J. L. Voss, R. F. Zimmerman, H. O. von Deilen, N. A. Bertha, F. J. Benz, P. B. Patton and D. J. Terreri) have been especially faithful in their regular attendance and assistance in the functioning of the Society. Miss Janet Clark has continued as Executive Secretary and the thanks of the organization is tendered her for her faithful and untiring service.

OCEAN

Carmine L. Pecora, M.D., President, Toms River

The year ending February 29, 1952, proved to be one of the most active in the history of this society. The following report is a brief summary of the year's accomplishments.

Nine monthly meetings were held during the year. Whenever a guest speaker had been invited, the meeting was preceded by a dinner at which the Auxiliary was also invited. Six speakers honored us during the year.

At every other meeting, interesting medical subjects and committee reports were followed by general discussions and presented a wealth of information to all members.

All committees functioned actively and well during the past year. Reports of their activities is included in the minutes of the society.

The By-Laws Revision Committee presented such changes as to conform with the recommendations and activities of the State Society. Elections are now held in February and installation of officers takes place in March.

Full cooperation of the Society with such projects as the Red Cross Blood Bank Program, The Cancer Fund, and Heart Fund, was recommended and carried out.

Special attention has been given to combating socialized medicine. Here the assistance of the Woman's Auxiliary was mustered with results that were most effective.

The Society cooperated fully with local activities including hospitals, health and welfare agencies, schools, the Ocean County Centennial Committee and many others who solicited our support.

The full support of the pharmacists in Ocean County aided in our efforts to distribute literature on socialized medicine and other timely subjects.

A special committee was established to handle the group insurance and Blue Cross Plan for the Society.

The Executive Committee met each month to carry out details and to coordinate the activities of the Society.

Further to increase interest in attending meetings, the Executive Committee recommended that a monthly *Bulletin* covering the highlights of each meeting be sent to every member. This was facilitated by the election of a corresponding secretary who volunteered to handle correspondence, record the minutes, send out notices and announcements and prepare such other material and information as may be useful to our members.

The March meeting for years, has been in the form of a dinner, entertainment and dance in honor of the Woman's Auxiliary. This year we were graced with the presence of Dr. Sigurd Johnsen. He was accompanied by his charming wife. He was particularly impressed with the excellent attendance and also complimented the Society for recognizing the ladies in this manner. He emphasized their importance in the ever present fight against socialized medicine.

We are looking forward to another big year in this fast growing county.

PASSAIC

Sandor A. Levinsohn, M.D., President, Paterson

The year 1951-1952 has been a busy and eventful one in the history of the Passaic County Medical Society. After much travail, our society finally moved into its own building. This was the fulfillment of a dream which we have had for many years. With location in our own quarters, a new spirit seemed to set in. Committees have become more active, the name of the society is more frequently before the public, and the sign in front of our building seems to proclaim that, after 109 years of existence, we have finally come of age.

In all our efforts regarding the building and other activities, our Woman's Auxiliary has been extremely helpful. They have helped in the furnishing and decorating of our new home, and have taken on as their own project, the furnishing of a special room to be regarded as the Woman's Auxiliary room.

In June 1951, the Fifth Annual Spring Conference of the Woman's Auxiliary was held in conjunction with the Passaic County Tuber-

culosis and Health Association at Camp Christmas Seal—the topic: "Health Council and Civil Defense". Here, the idea of a local Health Council, long discussed, was given concrete form which resulted in the appointment of a Steering Committee, consisting of Dr. Joseph M. Keating, Chairman; Dr. J. Allen Yager and Dr. Joseph E. Mott, to work with the Woman's Auxiliary to organize a Passaic County Health Council. This work is now going on and considerable progress has been made. The Auxiliary was also very helpful in arranging for the Open House held in our new building on February 17, 1952. In this event Dr. Frank W. Ash very rightly took great pride since the preparation of our building for occupancy represented almost a one-man job, that man being Dr. Ash.

In addition to our own society, the building is now occupied by the Medical-Dental Service Bureau and the Cancer Society. The meeting rooms are at present being used regularly by the various committees, the Passaic County Dental Society, the Woman's Auxiliary, and inquiries are being received from related groups and organizations who would like to make use of our facilities.

This building, which represents a great investment in time and money, will be worth while and successful only if all its facilities are in almost daily use. Dr. Wayne W. Hall is now working on plans for sectional meetings of the society and a graduate program, to be started in the fall. When this gets under way, all our committees have activated projects, and all related health groups turn naturally to our building as their meeting place, then—and only then— can we consider this project a success. Although much has been accomplished, much in physical improvement still remains to be done and I cannot urge too strongly that all unpaid Building Assessments be paid as soon as possible.

I here wish to place on record my thanks to the chairmen and members of the various committees whose reports appear in the *Bulletin* of the Passaic County Medical Society.

The Program Committee, under the Chairmanship of Dr. E. D. Lawrence, has done a particularly fine job. They arranged the finest series of monthly scientific programs that we have had in many years. The speakers were all of the highest calibre; and the meetings were well attended.

The Membership Committee, under the Chairmanship of our able and perennial Treasurer, Dr. Theodore K. Graham, handled its work with its usual facility so that we have practically no delinquent members. Our total membership is now 511, of whom 465 are Active Members.

A very important but little-heralded committee, which has been doing fine work in adjusting disputes, clearing up misunderstandings and in general preserving good public relations for the society, has been the recently activated Grievance Committee under the Chairmanship of Dr. Louis Shapiro. The problems of this committee have demanded time, tact and tolerance, all of which it has shown in great measure.

Our *Bulletin* which started modestly some years ago, has grown into a lusty booklet under the able editorship of Dr. Joseph E. Mott. The *Bulletin* now requires so much time that a reorganization of its management is necessary. With the June issue the editorship will be taken over by Dr. John A. Ianacone. He replaces Dr. Mott, whose resignation we accept with regret, after a long and successful service. Dr. Mott will continue as Consulting Editor. Mr. Randall Norris, our Public Relations Counsel, will become Business Manager of the *Bulletin*.

Our Speakers Bureau has been enlarged and and has become very active. Scarcely a day passes by without a request from some organization for a speaker. It is gratifying to know that the public is beginning to turn to the medical society for information on health matters. We can use more volunteers with speaking ability.

Another project, and one of the most important, has been the development of an Emergency Service Program with 24-hour telephone coverage. Recently, paid advertisements were run simultaneously in the leading newspapers of Passaic County explaining this plan as a public service. Additional publicity was given by news releases and editorial comment. I must emphasize the paramount importance of making this scheme work. Our entire public relations program may rise or fall on this one project. Every member must regard it as his own responsibility to see to it that his own patients are never left without medical coverage. The Emergency Program can be only that—a program for emergencies.

At the request of the State of New Jersey a new plan was arranged for re-examination of patients entitled to disability benefits. The panel of physicians called upon to make these examinations is continually being enlarged and the service to the Bureau markedly expedited.

Dr. John E. Leach has been named Chairman of a Committee on Placement of Physicians. This committee was organized because of frequent requests for information from phy-

sicians for opportunities for locating practices, as well as by communities in need of physicians. This committee can serve both the doctors and the communities.

Socially, the year developed several pleasant occasions. The Annual Dance of the Auxiliary was very well attended. The December meeting was combined with a dinner honoring Dr. Sigurd W. Johnsen on his election as State Society President.

It has been a busy year and a fruitful one. Medical societies in general, though highly regarded and most respected, tend to retire to ivory towers and keep aloof from mundane matters and practical problems. We in Passaic County have not been without this fault. However, our society is showing evidence of a growing awakening to the responsibility it owes to the communities we serve. It is beginning to grasp the need for reciprocal understanding between our patients and ourselves. It is becoming conscious of the importance of good public relations. We are becoming a well-organized, articulate group of professional men, each highly regarded by his own patients and as a group, looked to for leadership in health matters. This is all to the good.

We must continue to advise and educate the public in matters of health. We must police and discipline ourselves so there will be no opportunity for laymen to find fault. We must continue to raise the standards of medical and hospital practice, and we must furnish a forum for free and open discussion of medical and medico-economic problems.

All these aims our Society is trying to accomplish, with the help of its members and committees to whom I wish to express my sincere thanks for their splendid cooperation. I shall look back with pleasure to a year of service with some very fine colleagues.

SALEM

R. Louis Silverman, M.D., President, Penns Grove

The past few months have witnessed no striking change in the activities of the Salem County Medical Society. Within the past year, the new building of the Salem County Memorial Hospital has been put into active operation. Its expanded facilities of bed space, personnel, and laboratories has called for enlargement of the attending staff. This has been accomplished through the interest and assistance of numerous consulting and courtesy staff members from nearby Wilmington, Delaware; and by the addition of practitioners of several specialties opening offices within the county. Several of these new men are already active in affairs of the County Society.

The scientific programs of this year's meetings would be a credit to the efforts of the program committee of a county society of any size. It has been our pleasure to hear and meet men who are outstanding in their respective fields. Attendance at the meetings has been larger than in previous years, and speaks for a healthy state of the Society as a unit. The Emergency Medical Service is active and working in all of the county. The members of the Speakers Bureau have had occasion to speak to numerous groups about cancer detection, the narcotic danger and similar subjects throughout the county.

UNION

Louis S. Wegryn, M.D., President, Elizabeth

Our County Society membership in 1942 was 343; today we have 507 members. Ten of our members are in military service and eleven are residents in various fields of medicine. The Society now has nine emeritus members making a total membership of 516.

The Society has held all meetings this season at Johnson & Johnson's beautiful plant in Cranford. Because we have held our meetings in one place, centrally located, there has been improvement in attendance. We hope this will greatly increase next season.

Our group enrollment in the Hospital Service Plan of New Jersey has increased from

193 to 265 members. Another 75 members of the Society are enrolled through affiliation in schools, industry, groups and institutions. Our hope is that all members eligible for participation in the Plan will soon be enrolled. We have receive many favorable comments on the service by our members.

The Speakers Bureau has had the usual active season with more requests for speakers on cancer than on any other medical subject. Miss Helen German, executive secretary of the Union County Chapter, New Jersey Division of the American Cancer Society, always makes her requests for speakers through our Executive Office. We were interested to note the variety of subjects chosen by groups requesting medical discussions. The Linden Medical Society in conjunction with the Recreation Commission of Linden has drawn up a blueprint for a series of medical forums. This method of bringing to the public discussions on medical matters is not entirely new, but Linden may be among the first few cities in the country to try this type of program.

The Program Committee has followed the recommendation made last year that we schedule fewer scientific sessions as so many of our members are taking refresher courses or attending medical meetings of specific interest to their particular needs. Talks have been given on compensation laws, inheritance, social security and income taxes. The Woman's Auxiliary sponsored a joint meeting with the County Medical Society, having a prominent newspaper analyst and Dr. Harrold A. Murray, President-Elect of The Medical Society of New Jersey, as speakers. Our Fall Outing was held at Lake Hopatcong and was the most successful one ever held by the Society.

The Judicial Committee completed its first year. Although very few cases were presented, these brought out some of the important reasons for such a committee. Decisions by the committee were acceptable, and patients were pleased that they had such a committee to bring their problems to.

The Woman's Auxiliary is a stimulating and enterprising group. In 1942 the membership listed 60 doctors' wives. During the war there was very little activity. Upon the reorganization of the group in 1947, only 29 members were listed officially. Today we are proud to note that membership is 137. A very fine committee was at work this year and 32 new members have been enrolled. These members will not be counted officially by the State Auxiliary until the end of the fiscal year in February. Membership will then total 169. The Auxiliary was asked to collect excess drugs and surgical supplies for shipment overseas where there is a shortage of such material. Mrs. J. E. L. Imbleau headed this project and she has accomplished a great deal in a short time with the assistance of a very active committee. The Auxiliary is vitally interested in the care of the long term patient and is now working on practical plans to carry out their project.

The Plainfield Regional Defense Center was established this year to carry out the program for the collecting of blood for the armed forces in Korea. Dr. George A. Seymour, past president of the County Society, is medical director.

Our Workmen's Compensation Committee made a recommendation (which was adopted by the County Society) of establishing a minimum fee of $5 for first office visit for compensation accident cases and $4 for each subsequent visit.

The Emergency Medical Service is now almost four years old and is rendering a much needed service. It is not only rendering medical service to patients but its merit in public relations cannot be estimated.

The work in the Executive Office increases with the years as more and more of our residents are aware that the Society has a central headquarters where medical (and often personal) problems may be discussed and solved. The members themselves are using the facilities of the office more frequently than in the past. Our executive secretary attends many meetings and makes a great many calls. She has had to curtail some of her outside activities because of limited staff. It is hoped that the questionnaires sent to the doctors last year will be completed this summer. Correct information in the office is most important and should be kept up to date. This cannot be done without the cooperation of every member of the Society.

We have been pleased at the interest displayed by the members in the affairs of the Society and hope that this will continue to increase with the attendance growing in proportion.

The officers and members have cooperated and assisted in carrying out the work of the Society and it has been deeply appreciated.

TUBERCULOSIS

ABSTRACTS

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV May, 1952 No. 5

THE ABSORPTION, DISTRIBUTION, EXCRETION AND SHORT TERM TOXICITY OF ISONICOTINIC ACID HYDRAZIDE (NYDRAZID) IN MAN

By DuMont F. Elmendorf, Jr., M.D., et al, The American Review of Tuberculosis, April, 1952.

Isonicotinic acid hydrazide (Nydrazid) has been demonstrated by Bernstein et al, of the Squibb Institute to have a considerable and unique inhibitory effect on the growth of mycobacteria *in vitro* and to exert an impressive degree of antituberculous activity in experimentally infected mice. Systematic studies of the pharmacology of this compound were conducted by Rubin et al, who defined the acute and chronic toxicities of the drug for several animal species. They found that isonicotinic acid hydrazide was well tolerated by dogs for periods of three to four months when administered orally in doses which provided theoretically effective concentrations in the plasma. As a consequence of these observations, an investigation in man of the pharmacodynamics and antituberculous activity of isonicotinic acid hydrazide was started in November 1951 on the New York Hospital-Cornell Medical Service. Observations made in this study, on the pharmacology and toxicity of the drug when administered to patients with pulmonary tuberculosis, form the basis of this report.

Patients. The patients chosen for study were all adults with pulmonary tuberculosis classified as far advanced or moderately advanced by the criteria listed in Diagnostic Standards of the National Tuberculosis Association (1950 edition). With a few exceptions the patients had had long courses of streptomycin and para-aminosalicylic acid (PAS) and were discharging tubercle bacilli which were insusceptible to streptomycin *in vitro*. The type and timing of the clinical, bacteriologic, and roentgenographic observations made of the course of the tuberculous infection during isonicotinic acid hydrazide administration were identical with those used in streptomycin and other chemotherapeutic studies.

Drug. The isonicotinic acid hydrazide* used was a highly purified crystalline powder incorporated into capsules containing 10.0 milligrams or 25.0 milligrams.

Dosage Regimen. For continued administration, the isonicotinic acid hydrazide was given orally in a total daily dose of 3 mgm per kilogram divided into two doses at approximately 12 hour intervals. Deviations from this regimen were made in certain individual experiments.

On the basis of the observations it appears that isonicotinic acid hydrazide (Nydrazid) can be administered daily for periods of four to sixteen weeks to patients ill with pulmonary tuberculosis without evidence of serious toxic reactions. The daily dosage regimen (3.0 milligrams per kilogram) generally used in the present study was associated with plasma concentrations of the drug which are considerably above those in the reported therapeutic studies in mice. The biologic studies

*Generously supplied as Nydrazid by E. R. Squibb & Sons, New York, N. Y.

with plasma, cerebrospinal fluid and tubercle bacilli in the present investigation indicate that the isonicotinic acid hydrazide distributed in the plasma and cerebrospinal fluid of man is present in an active form in terms of antituberculosis activity *in vitro*.

It appears that from the standpoints of distribution, maintenance of antimicrobial activity and short-term tolerance, isonicotinic acid hydrazide in man displays properties which are highly desirable in an antituberculous drug.

Summary

Isonicotinic acid hydrazide ((Nydrazid) was well tolerated in man in daily oral doses of 3.0 milligrams per kilogram for periods of four to sixteen weeks. The drug was rapidly absorbed and a high percentage was excreted in the urine during the 24-hour period after ingestion. Appreciable concentrations of the drug are present in the cerebrospinal fluid within three hours of an oral dose of 2.0 to 3.0 milligrams per kilogram in patients without meningitis. In patients with tuberculous meningitis the concentrations of drug in the cerebrospinal fluid after oral administration are substantially higher than the concentration necessary to inhibit *M. tuberculosis* H37Rv *in vitro*.

The administration of isonicotinic acid hydrazide for the 4 to 16 week period on the 3.0 mgm per kilogram daily dose has not been associated with any manifestations of drug toxicity in any of the patients studied. It is probable that with higher doses or more prolonged administration, evidences of toxicity may be encountered.

The period of study has been too short to permit any statements concerning the possible emergence of drug-resistant strains of *M. tuberculosis* in the patients who have received the drug.

Finally, though isonicotinic acid hydrazide possesses a high degree of activity against *M. tuberculosis* in animals and in the body fluids of man, it is not possible from the present observations to make any positive statement concerning the therapeutic value of this compound in the treatment of tuberculosis.

HYDRAZINE DERIVATIVES OF ISONICOTINIC ACID IN THE TREATMENT OF ACTIVE PROGRESSIVE CASEOUS-PNEUMONIC TUBERCULOSIS

By Edward H. Robitzek, M.D., and Irving J. Selikoff, M.D., The American Review of Tuberculosis, April, 1952.

In the synthesis of the antituberculosis compound thiosemicarbazone of isonicotinaldehyde, Fox of the Roche Chemical Research Laboratories used isonicotinic acid hydrazide as an intermediate. Schnitzer and Grunberg in the Roche Chemotherapy Laboratories found that this compound exerts a striking and lasting effect on experimental tuberculosis in mice. A series of derivatives of isonicotinic acid hydrazide which were then studied showed that some of these exerted antituberculous activity similar to the original isonicotinic acid hydrazide. Three compounds have been consecutively and concurrently investigated clinically since June, 1951. (1) 1-isonicotinyl-2-glucosyl hydrazine, (2) 1-isonictotinyl-2-isopropyl hydrazine (Marsilid), and (3) isonicotinic acid hydrazide (Rimifon).

Ninety-two patients with pulmonary tuberculosis have been under treatment with two hydrazine derivatives of isonicotinic acid, (a) 1-isonicotinyl-2-isopropyl hydrazine (Marsilid) and (b) isonicotinic acid hydrazide (Rimifon). Of these, 44 cases of acute febrile, progressive caseous-pneumonic tuberculosis serve as the basis for this report.

Therapy to January 15, 1952 has ranged from four to fifteen weeks. All patients experienced rapid and marked reversal of their original toxic states, as evidenced by gain in weight, return of appetite, defervescence, and a sharp return in sense of well-being. Cough and expectoration have been eliminated or markedly reduced. Sputum bacillary contents have been reduced in 38 cases, and in 8 cases examinations for acid-fast bacilli on stained smears have been repeatedly negative.

On roentgenographic examination, reduction in cavity size has occurred in 17 cases and apparent diminution in exudate has occurred in 5 cases.

Therapeutic effects of isonicotinic acid hydrazide (Rimifon) after four weeks at 4 mg. per kg. daily are roughly equivalent to 1-isonicotinyl-2-isopropyl hydrazine (Marsilid) at the same dosage and for the same period. The incidence of early side reactions is moderately higher with the isopropyl derivative (Marsilid) therapy at comparable dosages although, from animal studies, isonicotinic acid hydrazide (Rimifon) might have a higher potential delayed toxicity.

The hydrazine derivatives of isonicotinic acid exert an impressive therapeutic effect upon the course of acute caseous-pneumonic tuberculosis in humans.

CURRENT STATUS OF ISONICOTINIC ACID HYDRAZIDE IN THE TREATMENT OF TUBERCULOSIS

The Executive Committee of the American Trudeau Society (Medical Section of the National Tuberculosis Association) has reviewed the evidence on the antituberculous activity of isonicotinic acid hydrazide placed before them through the courtesy of Hoffmann-LaRoche, Inc., of E. R. Squibb & Sons and investigators cooperating with them, and on the basis of this information makes the following statement for the guidance of the medical profession.

1. CHEMICAL STRUCTURE: Isonicotinic acid hydrazide[1] is a chemically pure synthetically produced substance of the general formula $C_6H_7N_3O$. It is obtained in almost colorless crystals which are highly soluble in water. The closely related isopropyl derivative is also being studied.[2] Isonicotinic acid hydrazide is also related to pyrazinamide[3] and to amithiozone.[4]

2. ACTIVITY IN VITRO: Isonicotinic acid hydrazide is bacteriostatic *in vitro* against *M. tuberculosis* H37Rv in a concentration as low as 0.02 to 0.06 mcgm./ml. Apparently it has a very narrow antibacterial spectrum, being ineffective *in vitro* against the common gram-negative and gram-positive pathogenic bacteria, certain protozoa, and the influenza virus in mice. It may possess slight antifungal properties.

3. ACTIVITY IN VIVO: In several species of experimental animals experiments on the effectiveness of isonicotinic acid hydrazide against infection with virulent human strains of *M. tuberculosis* have given promising results in arresting the experimentally produced disease. From these data isonicotinic acid hydrazide appears to be approximately the therapeutic equivalent of streptomycin, at least early in treatment. Observations as to the emergence of strains of tubercle bacilli which may be resistant to isonicotinic acid hydrazide, either *in vitro* or *in vivo* are meager, and it is not known if such strains will emerge or will have therapeutic significance. A definite increase in resistance has been obtained *in vitro* with one strain (BCG).

4. TOXICITY AND PHARMACOLOGY: Although the toxicity of isonicotinic acid hydrazide has been determined fairly accurately in several species of animals, some aspects of the pharmacology and toxicology of the drug have not been elucidated. It now appears that both isonicotinic acid hydrazide and its isopropyl derivative are of relatively low toxicity in effective dosage ranges. The drugs are apparently largely excreted in the urine. After administration they appear to be well distributed throughout the body within an hour.

5. DOSAGE: On the basis of preliminary studies, the indicated daily dosage is in the range of 3-5 mg./Kg. body weight (150-300 mg. per day for the average adult) which is given by mouth in 2 or 3 divided doses. The drug may also be given parenterally.

6. TOXICITY IN MAN: In the dosage range indicated, preliminary observations in man indicate that there is little significant toxicity. The following have been observed but are usually transitory even though drug administration is continued: (a) constipation, (b) difficulty in starting micturition (in males especially), (c) increased reflexes, (d) positional hypotension and dizziness, (e) eosinophilia, (f) slight drop in hemoglobin concentration, (g) occasional casts and traces of albumen and reducing substances in the urine. Toxic effects on the eighth cranial nerve, impairment of renal or hepatic function, or dermatologic manifestations have not been observed so far.

7. ACTIVITY IN MAN: In man preliminary observations on the effect of isonicotinic acid hydrazide on the course of tuberculosis have largely been limited to patients with far-advanced pulmonary disease, extensive tissue destruction, positive sputum and, as a rule, considerable symptomatology, many of whom have failed to respond or would not be expected to respond to other available therapy. In such patients, treated with 3-5 mg./Kg. per day for up to five months of therapy (the majority treated for 2-3 months), the following changes have been observed:

(a) reduction in fever, if present, in 2-3 weeks, in the majority, (b) reduction in cough, in the volume of sputum, and in the number of tubercle bacilli raised as determined by smear—no data from cultures are available on conversion of the sputum, (c) gains in appetite, weight, and strength, (d) some clearing of the reversible component of the pulmonary tuberculous disease by X-ray observation, (e) initial favorable response has been observed in non-pulmonary lesions and in a very few cases of miliary and meningeal tuberculosis.

8. PROBLEMS: Complete information is lacking on many aspects of the therapy of tuberculosis with isonicotinic acid hydrazide. Among the unknown are the following:

(a) the mechanism of action of the drug on the tubercle bacillus—whether it is tuberculocidal or

1. Trade name used by E. R. Squibb & Sons, "Nydrazid"; by Hoffmann-LaRoche, Inc., "Rimifon".
2. Trade name used by Hoffman-LaRoche, Inc., "Marsilid".
3. Trade name used by Lederle Laboratories, "Aldinamide".
4. Trade name used by Schenley Laboratories, "Tibione".

tuberculostatic; the effect upon the enzyme chemistry of the tubercle bacillus, etc., (b) the mechanism of action upon the host—basically, the precise toxicity in man, (c) optimal dosage: the number of milligrams per day; whether it needs to be given every day; the optimal mode of administration, (d) the duration of therapy: whether its effect is comparable to that of streptomycin and para-aminosalicylic acid (PAS), indicating relatively long courses of treatment, or whether shorter courses may be as effective, (e) the rate of emergence of drug-resistant strains of tubercle bacilli, (f) the effect of the drug upon the bacteriology of the patient: data are lacking on conversion of sputum by culture; the tissue bacteriology after varying amounts of treatment will need study, (g) the possibility of relapse after initial improvement, (h) whether basic systemic therapy of tuberculosis can be modified in treatment with isonicotinic acid hydrazide.

9. Precautions: At present there is no reason to believe that the fundamentals of therapy of tuberculosis should be altered when isonicotinic acid hydrazide is employed. Patients receiving the drug should be hospitalized and studied in institutions where not only potential toxic manifestations may be watched for more carefully, but where effects upon the underlying tuberculosis may be carefully observed so that suitable alterations of therapy may be initiated when indicated. Routine laboratory precautions should include frequent blood counts and urinalyses, neurologic examinations, and tests for renal and hepatic insufficiency.

10. In General: The introduction of a new drug in the therapy of tuberculosis is likely to raise more questions for a few years than it will answer. Whether isonicotinic acid hydrazide or its isopropyl derivative will accomplish more than streptomycin and PAS is not known at present. It may prove to be an additional drug of great value. It may be years before its exact contribution to the therapy of tuberculosis can be assessed accurately. A large reservoir of undetected and untreated cases of active tuberculosis exists throughout the United States, and there is every expectation that in spite of the more effective chemotherapy of tuberculosis currently available, the need for hospitalization in institutions with qualified personnel and adequate laboratory facilities will increase rather than decrease. There is at present no basis for expecting that isonicotinic acid hydrazide, or any other drug, can safely be counted upon to reduce the duration of hospitalization. Rather, it may lead to prolongation of hospital treatment, since effective chemotherapy may facilitate desirable forms of therapy not otherwise possible.

It should be emphasized strongly that, with more numerous effective antituberculous compounds available in the treatment of tuberculosis, more intensive case finding than ever will be indicated. Only through this means can maximum advantage be taken of improvements in therapy.

11. Summary: After a review of available data on the action of isonicotinic acid hydrazide and its isopropyl derivative upon the tubercle bacillus *in vitro*, and upon the course of experimental tuberculosis in animals and clinical tuberculosis in man, it may be stated that their demonstrated action, although highly encouraging, appears in no way to alter the basic principles of the treatment of tuberculosis as presently understood. Much more work will need to be done to ascertain the exact place of these drugs in the treatment of this disease. It is anticipated that further information will accumulate rapidly.

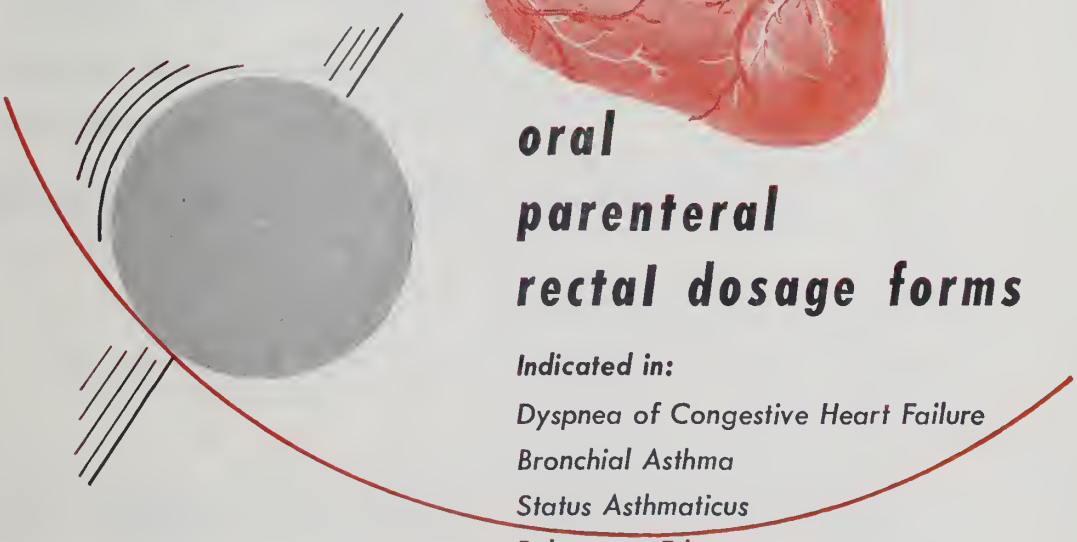
NEW JERSEY TRUDEAU SOCIETY
is the medical section of
New Jersey Tuberculosis League
15 East Kinney Street, Newark 2, New Jersey

SEARLE

Aminophyllin*

increases cardiac output

"improves exercise tolerance by 42 per cent"[1]



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Indicated in:

Dyspnea of Congestive Heart Failure
Bronchial Asthma
Status Asthmaticus
Pulmonary Edema
Control of Cheyne-Stokes Respiration

Also of value as: Peripheral Vasodilator[2]

1. Kissin, M.; Stein, J. J., and Adelmon, R. J.: Angiology 2:217 (June) 1951.
2. Rickles, J. A. J. Florida M.A. 38:263 (Oct.) 1951.

*Contains at least 80% of onhydrous theophylline.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

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*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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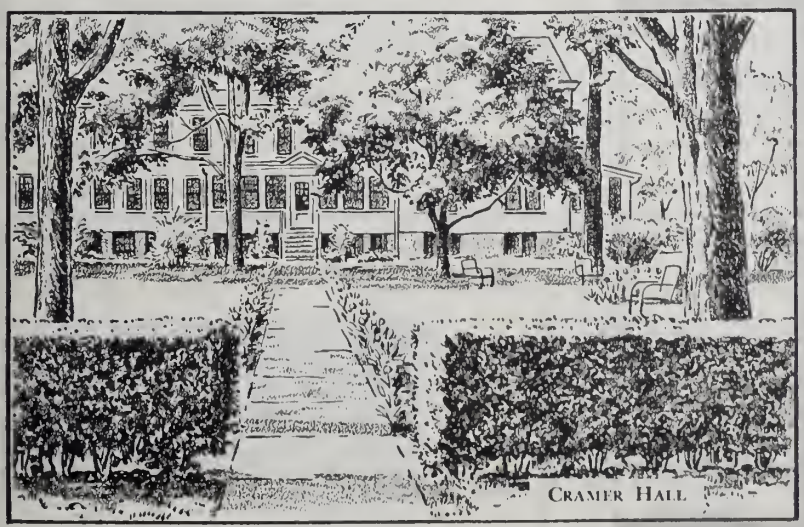
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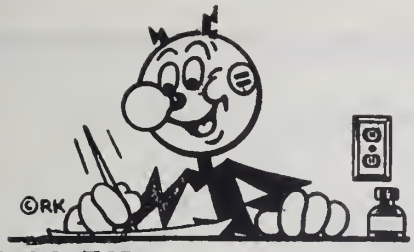
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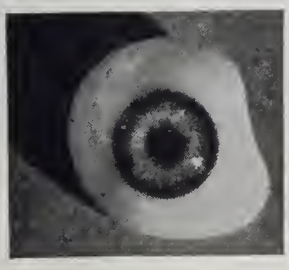
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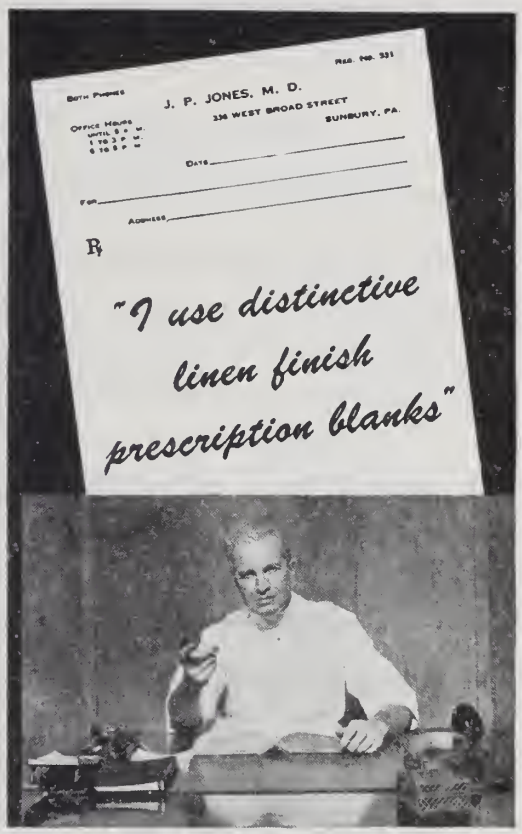
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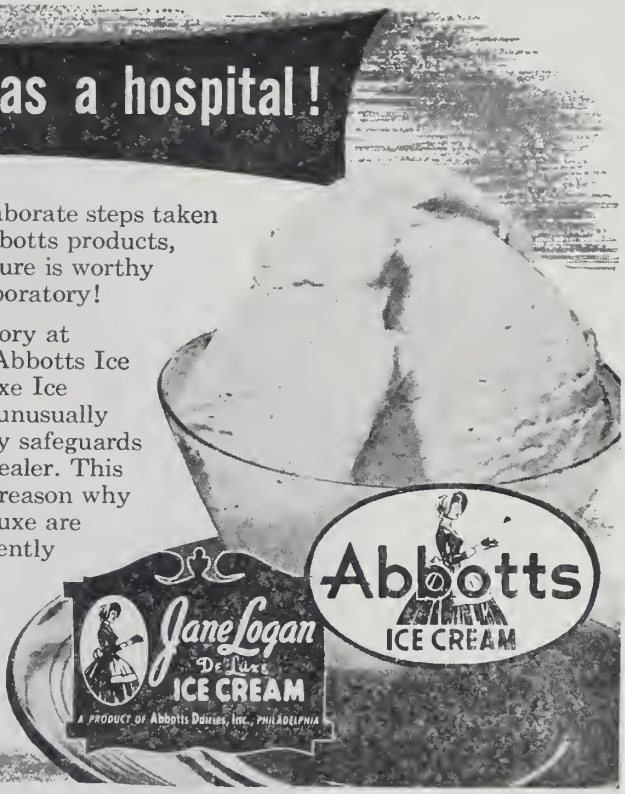
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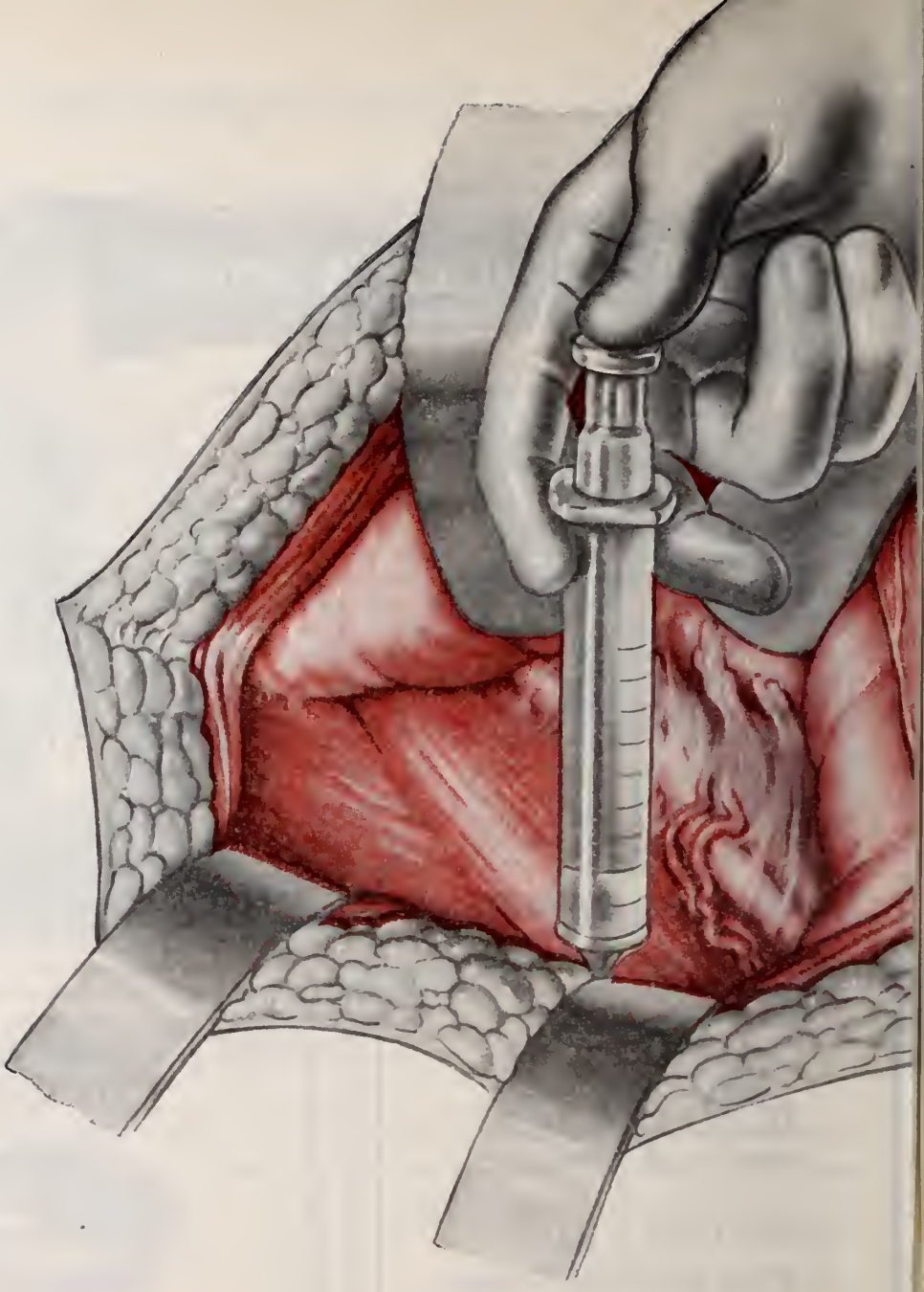


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*Gordon, Harry H.: Feeding of Premature Infants, American Journal of Diseases of Children 73:713 (June) 1947.

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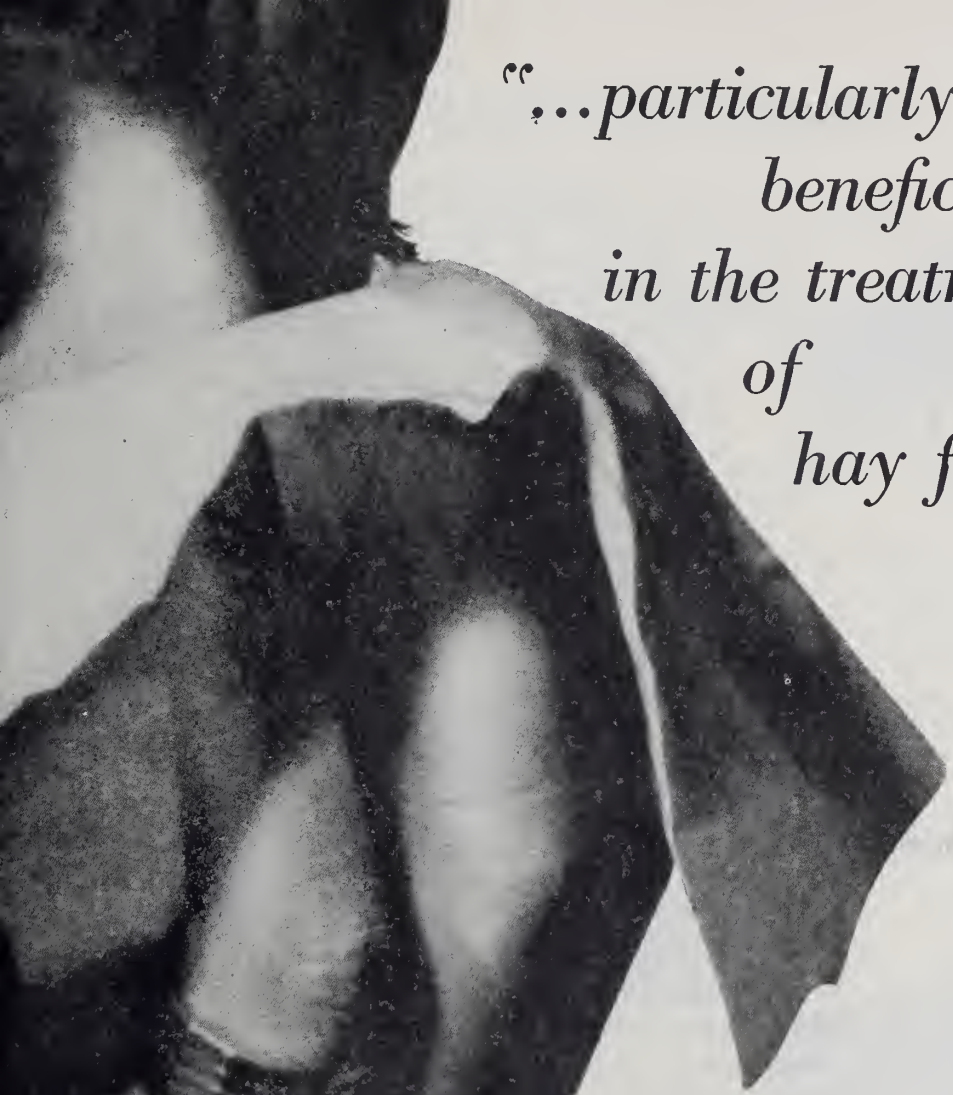
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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

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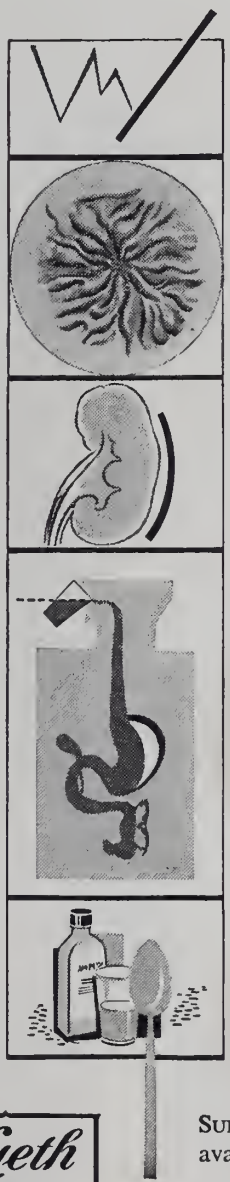
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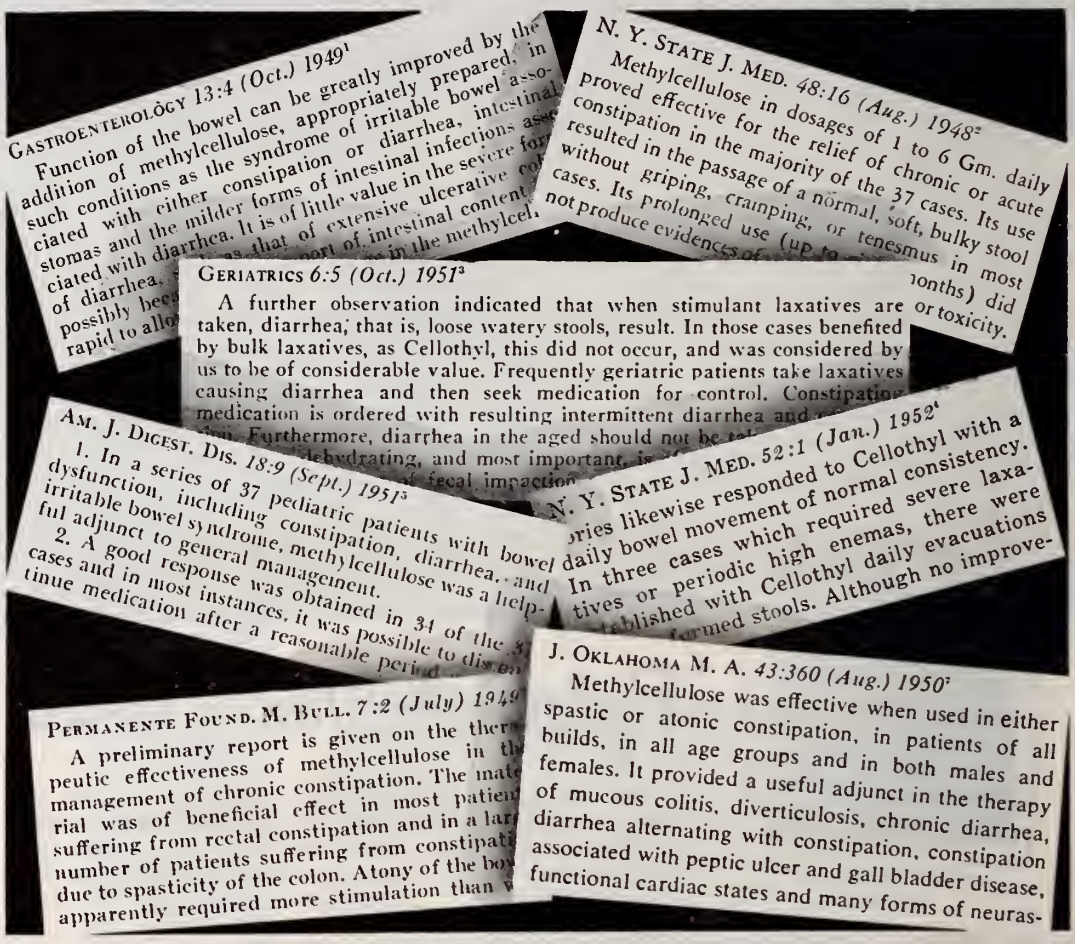
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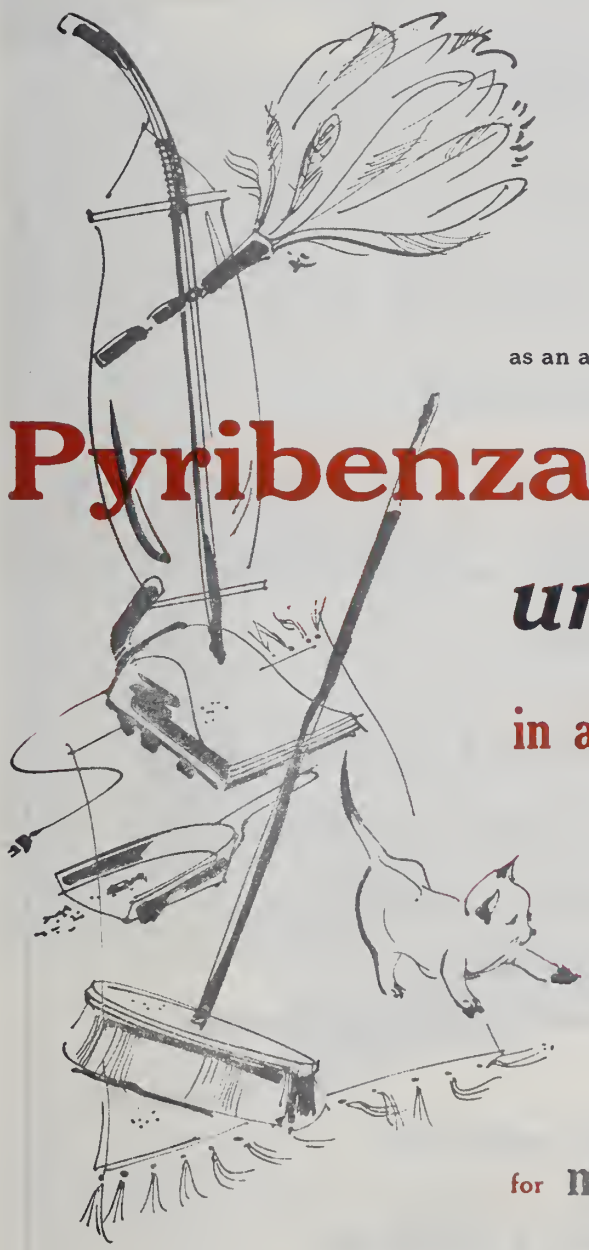
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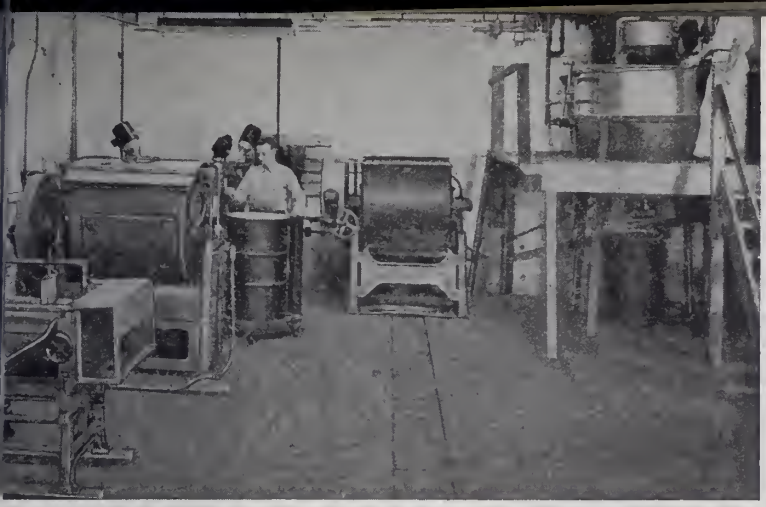
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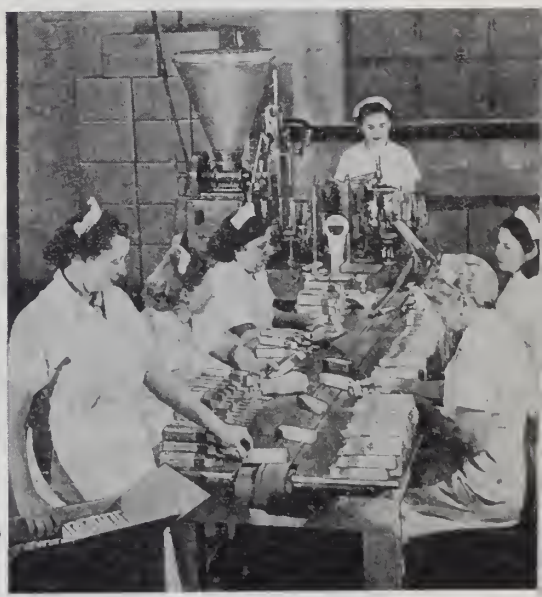
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PRESENTING HARROLD MURRAY



Those two "R's" in his first name could stand for "reliable" and "resourceful"; or for "robust" and "restless". Harrold Murray has certainly displayed all four qualities during his distinguished career in New Jersey medicine and in New Jersey civic activities. And he will need all four qualities in the year to come.

Born in Newark, he was graduated from Seton Hall and from Columbia University's College of Physicians and Surgeons. The latter event took place in 1920. Like most doctors of that day, he started in general practice. However pediatrics soon snared his interest and for thirteen years he worked closely with Bela Schick at New York Mt. Sinai Hospital. Harrold Murray was a pioneer in recognizing that pediatrics was a form of sociology as well as a form of medicine; that the doctor's whole duty to the child was not accomplished by writing prescriptions or feeding formulas; that the entire social and cultural milieu had an influence on child growth and that it

was a doctor's job to be sensitive to—and sometimes to exert influence on—those emotional and social forces which help mould the developing personality. All of this sounds like the A B C's of modern pediatrics. But it was a novel idea in the late 1920s; and in New Jersey, Harrold Murray was a pacemaker in that approach to pediatrics.

His tremendous and effective interest in the sociology of childhood is reflected in unremitting service to civic groups. He is one of the few physicians to have served on the Board of Trustees of the New Jersey Welfare Council. He has been president of the state Child Caring Group, on the Board of Directors of the local chapter of the American Red Cross, vice-president of the county Tuberculosis League, trustee of the Essex County Service for the Chronically Ill, member of the Governor's Committee on Youth, of the Board of Directors of the Welfare Federation, and chairman of the Family Services Division of the Newark Council of Social Agencies. And as his fellow board members will testify (sometimes proudly, sometimes ruefully) Harrold Murray doesn't just stay on the letterhead. He gets off the letterhead and into the work of the organization.

He is chief of pediatrics at St. Michael's Hospital, City Hospital and St. James Hospital in Newark. He is consulting pediatrician to eight other hospitals. He is a member of the national Executive Board of the American Academy of Pediatrics—one of the very few New Jersey physicians to have attained that recognition. He is, naturally, a diplomate of the American Board of Pediatrics. For years he was a lecturer on child care at Columbia University. He recently launched a civic-service television project, plugging his favorite topic (you've guessed it: child care). He cut short his budding television career only last month in order to go into high gear as President of The Medical Society of New Jersey.

Harrold Murray obviously—and appropriately—likes children. He has six of his own—one is with the Medical Corps in Korea, one daughter is married (to a pediatrician, of course), one son is a priest. The other three are in colleges or preparatory schools.

In spite of carrying on a large pediatric practice, in spite of an uninterrupted career of civic service, in spite of ceaseless and successful efforts maintaining the pediatric services at three hospitals, Harrold Murray has also found time to labor in fields of organized medicine. In Essex County he worked his way up through various committees, eventually becoming president of that society. At the same time he was contributing effort and interest to The Medical Society of New Jersey, a fact which the House of Delegates recognized in 1949 by naming him Second Vice-President. During the last three years he has been devoting more and more of his very considerable energies to the state society.

Some of the skeptics on the sidelines say that medical societies are too much concerned with the narrow problems of individual patient care, too little concerned with the broader community and citizenship facets of medical practice. And maybe some medical groups have to plead guilty. But not The Medical Society of New Jersey. Not with Harrold Murray as its President.

PRESIDENT'S MESSAGE

TEAM WORK FOR SUCCESS

No individual or group of physicians can conduct the affairs of a medical society successfully without the help of every member. If we are interested in preserving the practice of medicine as we have enjoyed it in the past, we must be prepared now to take our place in the planning and implementation of the programs that will offer service to the people of our state.

There are some gaps in our present set-up for adequate medical care, but every one of these inadequacies can be overcome by the concentrated efforts of all our members. We have many facilities to aid us in this endeavor. Committees have been carefully selected to initiate programs. The Woman's Auxiliary stand ready to help us at all times. Our officers and the Board of Trustees will guide us in our decisions. We have a well trained and experienced office staff constantly at our disposal.

We have established liaison with every lay and professional agency interested in the health and welfare of our citizens. We cannot function effectively unless we have the whole hearted support of all of these groups. Dentists, nurses, technicians, social and welfare agencies, either on a state or local level, are all important members of the team.

Our goal is the formation of and the preservation of adequate health standards in New Jersey. Every individual member of the society has a definite role to play. We cannot hope to have healthy citizens unless we as individuals see to it that facilities are made available for good medical care. We cannot leave it to certain groups in the medical society to perform this function. In our own communities we must become interested in all programs that concern health and welfare. Lay organizations are eager and anxious for our help in their planning. We must realize that in all projects aimed for the health of the community, physicians must play an important part. This does not necessitate that the doctor be an officer of his medical society. Even though he or she be very young in the practice of medicine, he can be a definite asset to these agencies. With this interest his relationship with the community will improve and he will be considered as a guiding factor, someone to be admired and respected.

If we are to regain and maintain the esteem which our forefathers had in the past, we must convince the community in which we live that we are still physicians vitally interested in *all* the things that help make people healthy and happy; that we are not solely concerned with making a living out of medicine, but that we are loyal members of an honored profession which, for centuries, has fulfilled the high traditions for giving service and help to those in distress.

As your President, I would like to feel that, for this year, I could be a sort of a manager of a very well organized team by whose careful planning and performing the realization of winning the pennant for good health standards in New Jersey would be a definite accomplishment.

Harrold A. Murray, M.D.

ORIGINAL ARTICLES

MILIARY AND MENINGEAL TUBERCULOSIS
THERAPY AND RESULTS*

SAMUEL COHEN, M.D., Jersey City, N. J.

Streptomycin can be said to have definitely cracked the physiologic-chemical "curtain" within the tubercle bacillus. While it is not the ideal drug, it is the basic chemotherapeutic agent in the treatment of miliary and/or meningeal tuberculosis today. The purpose of this paper is to present briefly our experiences relating to the results and management of these two serious complications.

GENERAL STATISTICAL DATA

Table 1 shows how patients with meningitis and miliary tuberculosis fared before the era of chemotherapy (control series). The mortality was 100 per cent and the survival period was very short—from a few days to a few weeks. By contrast, Table 2 refers to a treated group of 25 cases of miliary and/or meningeal tuberculosis admitted during the four year period between January 1, 1947, and December 31, 1950. (There were 5 children and 20 adults and the ages ranged from 1 to 54 years.) The follow-up status of the patients is given as of one year later: December 31, 1951. Eight patients or 32 per cent are still living with an average survival time of 31 months. The longest survival has been for 57.5 months. The 25 cases have been divided into 3 groups with survival and mortality figures for each group. The status of the 8 survivors is shown in Table 3. Five of the 8 are children and 4 of the 5 had had meningitis. One of these children also developed meningococcic meningitis, at a subsequent date. She is living 57.5 months after therapy was begun. The only patient now working is an adult, living 39 months after treatment was started. The miliary tuberculosis cleared on x-ray. In addition he had a right nephrectomy for ulcerative tuberculosis of the kidney in November 1948.

* From the B. S. Pollak Hospital for Chest Diseases, Jersey City, N. J.

MILIARY TUBERCULOSIS

Four patients had miliary tuberculosis with meningitis and eight without meningitis. Complete regression of the miliary seeding on x-ray was noted in 4 cases, partial regression 5, no regression in one. The causes of death were: meningitis 3 cases, marked toxemia 1, pulmonary embolus (following operation for Pott's disease at another hospital) 1 case, paralytic ileus (following appendectomy) 1 case, tuberculous peritonitis 1 case. In the surviving patients (42 per cent) the distribution of residual active or quiescent tuberculous foci was: Pott's disease 2 cases, pulmonary involvement 1 case, tuberculous prostatitis 1 case, no evidence of clinical activity 1 case.

Patients with miliary tuberculosis frequently develop meningitis during or after chemotherapy so that examination of the spinal fluid is warranted at the first suggestion of meningeal involvement.

MENINGEAL TUBERCULOSIS

Table 4 lists the cerebrospinal fluid findings just before therapy in 17 cases. Tubercle bacilli are rarely recovered on smear of the initial specimen but active therapy should be undertaken immediately if the cytologic and chemical findings are consistent with a diagnosis of tuberculous meningitis—because culture and animal inoculation reports are not available for several weeks. The latter were positive in 10 patients and in 2 the diagnosis was confirmed by necropsy. While the tubercle bacillus was not recovered in the 5 remaining ones, there existed no doubt as to the etiology; 2 of these had associated miliary tuberculosis and the others had involvement of the lungs with meningeal symptoms and signs and characteristic spinal fluid findings for tuberculosis.

After treatment has been started, serial ex-

aminations of the spinal fluid must be done. Several points deserve attention in interpreting the significance of these studies during and after therapy:

(1) As the meningitis improves, the sugar most frequently returns to normal before the protein or chlorides.

(2) The Levinson test is positive and the colloidal gold curve is abnormal in the active phase of the disease but they become normal as the process comes under control.

(3) Conversion to normal cytologic and chemical findings in the fluid is more important prognostically than conversion to a negative culture for tubercle bacilli.

(4) The probable superimposed chemical meningitis caused by the intrathecal use of streptomycin should be considered. Detailed reference to this has been made in an earlier publication.[1] Streptomycin or dihydrostreptomycin given intraspinally in the dosage of 0.1 Gram (the usual therapeutic dose) can be expected to produce a chemical arachnoiditis which will contribute to the abnormal spinal fluid produced by the tuberculosis itself. Such a chemical meningitis may be anticipated to clear in a few weeks and from our limited studies, it would appear that persistence of abnormal findings (particularly increased cell count and protein) beyond a period of perhaps 6 weeks after intrathecal administration of streptomycin has been stopped, should be ascribed to the tuberculous involvement and not to the antibiotic.

The results of therapy in a total of 17 meningeal cases, 13 without miliary and 4 with miliary tuberculosis, are briefly summarized as follows: Four (or 23 per cent) are still living (an average survival of 30.6 months in the former group and 27 months in the latter group). All of the surviving patients are children, one is hospitalized and 3 are at home. Complications of the basic disease (and/or therapy?) are apparent in 3 patients: (1) paresis of the left arm and leg is present in the hospitalized child; (2) one child at home (living 21.2 months) developed hydrocephaly, blindness, deafness and spasticity of the lower extremities; (3) the third patient, age 8, and the longest survival (57.5 months) was well until 1950 when she developed epileptiform seizures which have not recurred in the past 6 months. The child is well developed and apparently has no significant mental retardation. An electro-encephalogram in January 1952, showed an abnormal tracing consistent with a convulsive disorder. Another child at home is clinically well and normal and alive 27 months since inception of treatment. She also had miliary tuberculosis which disappeared on the chest film. The electro-encephalogram is normal.

Some important factors which influence the prognosis in tuberculous meningitis are: (1) the duration of meningitis prior to onset of treatment; (2) the presence or absence of associated tuberculoma. The latter are common precursors to meningitis and are encountered more frequently in adults. This may be one of the chief reasons, why more children than adults survive. Such lesions, embedded in the brain are less exposed to the penetration of streptomycin in an adequate and sustained concentration. Because the tuberculoma is a potential feeding focus for re-infection of the meninges, the prognosis in tuberculous meningitis is much more unfavorable than in the meningococcic or pyogenic meningitides; (3) the presence or absence of associated acute miliary tuberculosis. In the former case, the prognosis is, of course, poorer; (4) age of patient, child or adult; (5) adequacy of treatment.

THERAPY

The therapeutic regimen for miliary and meningeal tuberculosis has been modified many times in the past few years as experience increased and supplementary antibiotics became available. For this reason, it would be superfluous to present the specific chemotherapeutic data for each of the cases treated in our group. More instructive would be the presentation of suggested plans of treatment in the light of current trends. A rigid system of dosage and technic of administration, especially in meningitis, is doomed to failure because it is opposed to the biopathology of tuberculosis. Treatment must be regulated chiefly on the basis of clinical and laboratory findings. Some controversy exists as to the necessity for the intrathecal use of streptomycin in meningitis. On the basis of the writings of the great preponderance of observers, both American and foreign, who report favorably with the intrathecal administration of streptomycin, I believe that *at present* it would be best not to

1. Cohen, S., and Gans, R.: Diseases of the Chest, 18:215 (1950).

deny to a patient with a serious complication such as tuberculous meningitis, the probable value of the intrathecal use of the drug.

(a) Suggested Plan of Treatment of Miliary Tuberculosis

(1) Streptomycin sulfate should be given intramuscularly — in the acute phase one Gram 2 or 3 times daily with later reduction in the daily dose (not less than 1.0 Gram). After several months, it may be feasible also in some cases to reduce the frequency of administration to 2 or 3 times weekly.

(2) Supplementary antibiotics should be given. To delay the emergence of streptomycin resistant tubercle bacilli, para amino salicylic acid is warranted. If the patient is very acutely ill, it may be given intravenously in the daily dosage of 15 Grams; for oral use, 12 Grams in 4 divided doses daily is adequate for adults. Promizole,† a sulfone, which it is stated enhances the effect of streptomycin, is also recommended; the daily dose depending on age usually ranges from 2 to 8 Grams daily.

(3) How long should therapy be continued? The consensus is that therapy should be maintained until the patient is asymptomatic and the chest x-ray film is negative for at least 6 months, although Promizole† can be given for many months longer (2 to 3 years). The drug may produce a reddish discoloration of the urine which should not be mistaken for hematuria. In some instances, it has a goitrogenic effect.

(b) Suggested Plan of Treatment of Meningeal Tuberculosis

The drugs used are the same as for miliary tuberculosis. In addition, present recommendation is also for the intrathecal use of streptomycin. This may be given in the dosage of 0.1 or 0.025 Grams (preferably the former dose if no toxic symptoms appear) daily for about 6 weeks, every other day for 2 weeks and then twice weekly for another 2 weeks, making a total of about 52 injections. The antibiotic should be given slowly and diluted in 10 cubic centimeters of sterile water. Placing the patient in the Trendelenberg position is desirable. Spinal fluid examinations should be done frequently during therapy and also at monthly intervals for at least one year after cessation of therapy in order to detect a relapse which may be revealed in this manner before the occurrence of abnormal neurologic symptoms and signs. Relapse should be treated with another course of intrathecal streptomycin. The use of the drug intramuscularly should be continued for 12 months. The daily dosage and frequency parallels that in miliary tuberculosis as does the administration of para amino salicylic acid. If streptomycin-resistant bacilli develop, the use of para amino salicylic acid intravenously to achieve high bacteriostatic concentrations may be of help. For spinal fluid block, some have advocated intraventricular or intracisternal injections of dihydrostreptomycin. In more recent reports, others have recommended the intrathecal use of heparin[2] or streptokinase[3] or tuberculin[4] to prevent or combat the adhesions. These latter agents need to be evaluated more fully and their routine employment is not advised at this time.

† Promizole is the registered trade-name of the Parke Davis Company's brand of thiazolsulfone.

2. St. Hill, A. C.: Journal of Clinical Pathology, 1:157 (May 1948).
3. Cathie, I. A. B.: Lancet, 1:441 (1949).
4. Smith, H. V., and Vollum, R. L.: Lancet, 259:275 (1950).

CONCLUSIONS

A group of 25 cases of miliary and/or meningeal tuberculosis admitted during a 4 year period (1947-1950 inclusive) and treated with antibiotics have been reviewed. Results in each group have been presented together with suggested plans of therapy. Chemotherapy of these two serious sequelae of tuberculosis demands:

(1) Administration of antibiotics for long periods to prevent relapses.

(2) A minimum of toxicity from their use.

(3) The lowest possible incidence of drug-resistant organisms which is best achieved at present by the simultaneous use of supplemental antibiotics.

At long last, antibiotics have made some inroad into these two previously hopeless complications. We do not now have the final formula for cure but at least the progress made is somewhat encouraging.

TABLE 1
BEFORE CHEMOTHERAPY*
CONTROL GROUP
1934-1938

	Cases	Mortality	Length of Survival
Meningitis	14	100%	5 to 17 days
Miliary Tbc (acute)	7	100%	13 to 34 days

* From the Tuberculosis Service, Jersey City Medical Center.

TABLE 2
WITH CHEMOTHERAPY*
25 Cases Adm. Jan. 1947—Dec. 31, 1950
Status of Cases as of Dec. 31, 1951

Type	Cases	Living	Died	Length of Survival**
Miliary without meningitis	8	4	4	*Living Cases:* 16 to 46 mos. av=35.2 mos. *Dead* 0.5 to 20 mos. av=10.8 mos.
Miliary plus meningitis	4	1	3	*Living Case:* 27 mos. *Dead* 1.9 to 10.4 mos. av=5.2 mos.
Meningitis without miliary	13	3	10	*Living Cases:* 13.1 to 57.5 mos. av=30.6 *Dead* 0.1 to 16 mos. av=4.9 mos.
Total	25	8 or 32%	17 or 68%	av. survival time (living cases) 30.9 mos.

* From the B. S. Pollak Hospital for Chest Diseases.
** From onset of therapy to death or from onset of therapy to Dec. 31, 1951.

TABLE 3
STATUS OF 8 SURVIVORS
As of Dec. 31, 1951

	Miliary	Miliary With Meningitis	Meningitis Without Miliary
In Hospital	2	0	1
Home	1	1	2
Working or Able to Work	1	0	0

TABLE 4
SPINAL FLUID FINDINGS PRIOR TO TREATMENT
17 Cases

Clear fluid	17
Increased cell count[5]	16
Increased protein	15
Decreased sugar	15
Decreased chlorides	14
Positive culture or guinea pig	10

5. In four of these there was predominance of polymorphonuclear cells.

Appreciation is expressed to Dr. B. P. Potter for consent to incorporate the cases from his medical service in this report.

ADDENDUM

In recent months, considerable interest has been aroused as to the efficacy of the oral administration of isonicotinic acid hydrazide in the therapy of tuberculosis. It is still too early to evaluate this drug completely, but preliminary reports indicate that this chemotherapeutic agent perhaps may be added to the current group of available antibiotics for therapy of meningeal and miliary tuberculosis.

Berthold S. Pollak Hospital

PATHOGENESIS OF CHRONIC ULCERATIVE COLITIS

A new concept of the pathogenesis of chronic ulcerative colitis has been proposed by Drs. Milton D. Levine, Joseph B. Kirsner, and Arthur P. Klotz, in the November 23, 1951, issue of *Science*. By special staining methods and phase microscopy, these investigators studied biopsy specimens from patients with chronic ulcerative colitis, and other acute inflammatory disturbances of the colon. They noted that sections of biopsy material from ulcerative colitis patients showed almost complete absence of the basement membrane ground substance of the epithelial cells, while the epithelial cells themselves remained intact. On the other hand, studies of biopsy material from patients with amebic colitis and colitis due to lymphopathia venereum showed severe inflammation and necrosis, but the basement membrane was unchanged. Finally the examination of sections from chronic colitis patients who were receiving ACTH indicated a partial restoration of the basement membrane ground substance.

These authors concluded that alterations in the basement membrane ground substance are fundamental in the pathogenesis of ulcerative colitis and point out that many of the associated clinical features of this disease, e. g., arthritis, erythema nodosum, and glomerulitis are compatible with the inclusion of chronic ulcerative colitis in the group of collagen diseases.

THE SOCIETY FOR THE RELIEF OF THE WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY

H. A. TARBELL, M.D., Newark, N. J.

A misunderstanding seems to exist among many of the families and members of the Essex County Medical Society, and of The Medical Society of New Jersey regarding membership and payment of benefits from the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey. Thus, a widow of a deceased member of The Medical Society of New Jersey, who has never joined the Widows and Orphans Society will call the treasurer and inquire how soon she can expect to receive the benefit. She thought that membership in the Medical Society entitles her to death benefits. It should be made clear that the two organizations are separate units, and have no connection with each other.

It is unfortunate that after 70 years of existence, there are so many doctors who tell us that they have never heard of the Society. Some go so far as to ridicule the idea of the Society, asserting that $500 benefit is too meager to attract any doctor's attention and that a physician should provide for his family by regular insurance or other means.

Our Society was never intended to be an insurance organization. It is only a helping hand Society which took the place of the old custom of passing the hat when one of our brother physicians passed on, and was started by a few noble-minded physicians who saw the necessity of such an organization. It is a copy of an English society of a similar name, which is over 300 years old, and our by-laws are practically identical with theirs. From a gathering of 10 charter members, who started the Society, we now have a membership of 613. The Society is managed by a Board of Trustees who give their time and services gratis. There are no salaried persons connected with the Society, the entire expenses being for printing, postage, et cetera, plus a small allowance for a clerk to help with the books.

By reason of protracted illness or financial reverses, many physicians die leaving practically nothing for their family. It is for these cases that the Society was originated and should be the reason why we should all be members. To help a brother doctor's needy family is our slogan.

Some of the misapprehension regarding the membership arises from the fact that the Essex County Medical Society assesses each member $1 per year to assist a living member in financial distress. This fund is not connected in any way with the Society, but there is a false idea among many members that the $1 per year assessment gives the right to expect collection of benefits from our Society in case of death.

The treasurer has many times been called by the widow of a non-member of our Society inquiring how soon we can send the benefit, as they need immediate assistance. Of course, our Society can do nothing for this family.

Strange as it may seem, many medical men have passed on suddenly, leaving no cash in the house. It has happened that the doctor died with the combination to his safe in his head, and under these circumstances with the considerable expense entailed by a death in the family, the widow is in a difficult position. This is where our Society is a friend in need, and we can give immediate assistance.

All New Jersey physicians, male or female, in ordinary good health, who belong to The Medical Society of New Jersey are eligible for election to membership. The treasurer* will send an application and a pamphlet describing our Society to any physician who might be desirous of becoming a member.

* The treasurer is Dr. H. A. Tarbell, 13 Pennington Street, Newark 5, N. J. Also see page 270 of this JOURNAL for further information.

13 Pennington Street

CLINICAL BALLISTOCARDIOGRAPHY IN OFFICE PRACTICE

FRANK J. BROWN, M.D., Point Pleasant, N. J.

The purpose of this paper is to indicate the value of the ballistocardiogram in cardiac diagnosis in actual practice in the light of our present knowledge. Though the horizon is wide in this field, much research must be done before ballistocardiography approaches our present knowledge and standardization in electrocardiography. However, the foundations of ballistocardiography have been laid securely and even with our present meager knowledge, it is being used with success in cardiac diagnosis.

The *electrocardiogram* measures electrical waves of cardiac origin. The *ballistocardiogram* measures a different and more vital function of the heart: the effect of the mechanical pumping action of the heart. These "recoil waves" when picked up and recorded produce a tracing known as a ballistocardiogram. The peaks and nadirs of the waves have been arbitrarily named G, H, I, J and K. G to H is a headward stroke, occurring simultaneously with the first heart sound. It represents the beginning of ventricular systole. J to K is a footward wave whose nadir occurs simultaneously with the closing of the aortic and pulmonary valves or the second heart sound. The time interval from G to K represents ventricular systole. The normal heart contracts and ejects blood with a characteristic "snap" which is reflected in the amplitude and form of HIJK strokes. The waves following L, M, N, O, et ecetera, are diastolic waves of which little is known at present. Various conditions, both cardiac and extra-cardiac, may alter this normal pattern. Research in ballistocardiography is concerned greatly with what are normal patterns and normal variations as well as with what are abnormal tracings and their clinical significance. Isaac Starr[1] has perhaps, given the greatest impetus to the science of ballistocardiography in a paper in which he revealed studies on an eight to ten year follow-up of apparently normal persons with abnormal ballistocardiograms. Starr[1] revealed that a significantly high proportion of clinically normal patients with abnormal ballistocardiograms developed manifest heart disease; whereas clinically normal patients with normal ballistocardiograms remained free of heart disease.

Anyone who can read electrocardiograms can, with some additional effort, learn to interpret ballistocardiograms. Even if one does not plan to do ballistocardiography, it is wise to learn more about what the ballistocardiogram can and cannot do, so this instrument may be used as an aid in cardiac diagnosis.

The electrocardiogram is a relatively insensitive instrument; for example, most cases of coronary insufficiency have normal electrocardiograms. The ballistocardiogram is a remarkably sensitive machine. Just how sensitive it is, may be inferred from the report by Starr.[1] Apparently the ballistocardiogram was able to give objective evidence of latent coronary artery disease before it became manifest. Reports in the literature have varied between a 100 per cent correlation[2] between abnormal BCG's* and clinical coronary insufficiency to 93 per cent.[3] This variation may be due to the standards used by different authors in determining what represents an abnormal tracing. Brown, Hoffman and de Lalla[2] consider abnormal respiratory variation (that is, variation in the amplitude of the complexes, inspiratory exceeding expiratory complexes) as evidence of grade I abnormality. At least grade I abnormality does exist in almost all cases of coronary insufficiency. However, pulmonary emphysema, pulmonary fibrosis, post-sympathectomy syndrome, and resistance breathing also produce this abnormality in the absence of coronary artery disease. Since the diagnosis of the anginal syndrome is based almost entirely on history alone, it is not unreasonable to assume there may be a diagnostic error in the 7 per cent diagnosed as coronary insufficiency with normal ballistocardiograms at rest and after exercise. Autopsy

* BCG is the accepted abbreviation for ballistocardiogram.

1. Starr, I.: American Journal of the Medical Sciences, 214:233 (1947).
2. Brown, H. R., Hoffman, M. J., and de Lalla, V.: Circulation, 1:132 (1950).
3. Traymor, Robert C., *et al.*: American Journal of Medicine, 148:6 (1952).

confirmation or a long term follow up is necessary to be absolutely certain of a diagnosis of coronary insufficiency. However, it is conservative to say that most cases of clinical coronary insufficiency with anginal syndrome have abnormal ballistocardiograms. A normal ballistocardiogram does not rule out coronary insufficiency but is good evidence against it.[4] One should seriously question a diagnosis of coronary insufficiency when a normal resting and post exercise ballistocardiogram is found. Further search in these patients occasionally reveals a hiatus hernia, radiculitis, gall bladder or gastro-intestinal disease as the cause of symptoms.

Among older subjects, a very high incidence of abnormal ballistocardiograms is found. In a survey of a group over the age of 30, Mandelbaum[5] found a curve of abnormal ballistocardiograms which showed a very close correlation to the incidence of coronary arteriosclerosis reported in autopsy records of similar age groups.

Cumbersome and expensive tables and apparatus were first used by Starr,[1] Nickerson, and others. These are no longer necessary since Dock[6] demonstrated that satisfactory ballistocardiograms could be obtained by resting the patient in the supine position on a rigid examining table. The motion of the body imparted by the action of the heart is picked up through a bar across the patient's shins and transferred to electrical energy by means of induction using a magnet and a coil of wire. The amount of current produced depends on the speed of the movements. This electro-magnetic device produces a "velocity trace". Other portable devices which measure displacement rather than velocity are of the photo-electric type and of the piezo-electric type. The instrument used in the present study was a Glennite Precision Ballistocardiograph.[7] This is a piezo-electric machine and hence gives a "displacement trace". A piezo-electric instrument depends upon strain put upon crystals of barium titanate when a brass pickup spring is bent. The amount of current generated is proportional to the displacement. This is then picked up and recorded by any direct writing or string electrocardiographic instrument. In this series, a Sanborn Viso-cardiette was used.

Taking a ballistocardiogram is neither difficult nor time consuming. Ballistocardiograms should be taken on a fasting stomach since eating tends to increase cardiac output. Caccese and Schrager[8] have demonstrated that cigarette smoking occasionally produces marked transient changes in the BCG which last from one to twenty minutes. Therefore it is advisable to see that the patient has abstained from smoking for at least one half hour before taking the BCG. Failure to observe this precaution may lead to serious diagnostic error. Exercise may produce abnormalities in the ballistocardiogram which are not present at rest. The normal myocardium responds to exercise by increasing output which is reflected in the amplitude of the complexes. Diminished or no increase in output is considered abnormal.

In a few cases it is impossible to obtain satisfactory ballistocardiograms. When body tremor or muscle tics are present (or when the patient is uncooperative) the trace becomes unreadable. Tachycardia over 140 or very rapid breathing also makes the tracing unsatisfactory. If the patient is exceedingly "nervous", reassurance and rest will help. Occasionally sedation is required. A newcomer in the field of ballistocardiography may confuse abnormality of the ballistocardiogram with artifacts due to somatic tremor. Experience soon enables one to tell the difference at a glance.

The following cases indicate those groups in which the ballistocardiogram is of (1) great value, (2) some value, (3) little or no value.

1. HIGH VALUE CASES

Anginal syndrome is the condition in which the ballistocardiogram is most useful. It is here the electrocardiogram fails, for (even after exercise) about 40 per cent still show

4. Brown, H. R., Hoffman, M. D., and de Lalla, V.: *Clinical Ballistocardiography*, Macmillan Company, New York (1952).
5. Mandelbaum, H.: New York State Journal of Medicine, 51:14 (1951).
6. Dock, W., and Taubman, F.: American Journal of Medicine, 7:751 (1951).
7. The Glennite Precision Ballistocardiograph is manufactured by the John Peck Laboratories of 60 East 42d Street, New York City.
8. Caccese, Anthony, and Schrager, Alvin: American Heart Journal, 42:4 (1951).

normal electrocardiograms. When the heart contracts in a hypoxic state, whether due to coronary arteriosclerosis, anemia, poor pulmonary ventilation or any other cause, the ballistocardiogram, in most cases, assumes a characteristic pattern. In addition to the abnormal respiratory variation mentioned above, early "M" configurations appear caused by a high H wave, low I nadir, and low J peak. It is preferable to call these complexes early M *configurations* rather than M *waves* to avoid confusion with the M wave in diastole. Anginal syndrome is still a clinical diagnosis but it is helpful to have that diagnosis supported by objective evidence.

Since the ballistocardiogram is a sensitive instrument it may be used to help rule out serious heart disease. The following case illustrates this point.

Case 1. A 43 year old male office worker developed symptoms of vague substernal oppression which occurred at rest as well as after exercise. The pain was sometimes relieved by bending his back to either side. He was *not* relieved with nitroglycerin. The entire clinical picture was not typical of the anginal syndrome. Physical examination and fluoroscopy revealed no abnormalities. Blood pressure was 145/85. Electrocardiogram at rest and after exercise was normal. The patient's resting ballistocardiogram (Fig. 1) was normal. After exercise, it remained normal with increased output. The patient, therefore, is probably *not* suffering from any significant degree of coronary insufficiency. Radiculitis of the thoracic spine is the more likely diagnosis.

A similar case with a different result is seen in the following:

Case 2. A 44 year old slightly obese male tavern keeper has been suffering with "anxiety tension" for three months. He complains of pain and soreness in his left chest and arm. This pain is not related to activity and not relieved by rest or nitroglycerin. He had sustained a compression fracture of the seventh thoracic verterbra one year ago. X-ray of the thoracic spine also showed hypertrophic spondylitis. Physical examination including fluoroscopy revealed no abnormalities. Blood pressure was 150/85. His resting electrocardiogram was normal. However his ballistocardiogram showed complexes characteristic of myocardial hypoxia, i.e. early M type configurations (Fig. 2). Since the patient was apprehensive it was decided that reassurance was in order and it is planned to follow him closely in the future. It is important to realize that at age 44, abnormal ballistocardiograms are found in a significant number of patients without other evidence of heart disease. The abnormal ballistocardiogram, although it indicates cardiac disease does not necessarily mean it is the cause of the symptoms at this time. In the meantime we may institute a program of weight reduction and a low cholesterol, low fat diet.

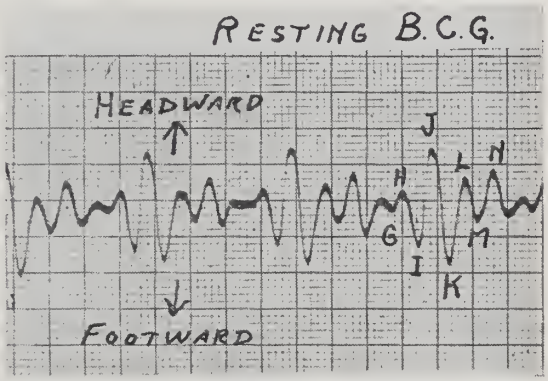


Figure 1. Case 1. Clinical diagnosis—probable dorsal radiculitis. Normal ballistocardiogram. Note clearly defined regular complexes.

In some instances we find cases in which the electrocardiogram is abnormal or questionable. Occasionally it is impossible to confirm or rule out cardiac abnormality by any other means. The following case illustrates this point.

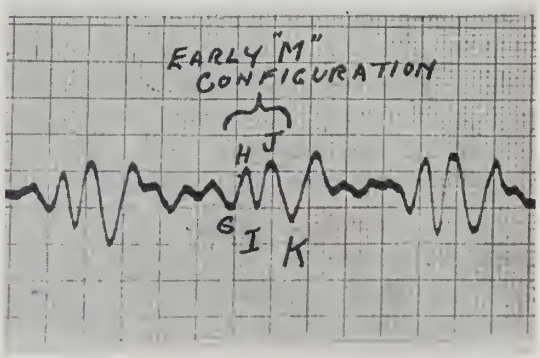


Figure 2. Case 2. Clinical diagnosis—anxiety state. Ballistocardiogram is abnormal showing early M configurations characteristic of myocardial hypoxia.

Case 3. A 35 year old female, laboratory worker was perfectly well with no complaints of any sort. She had an electrocardiogram taken out of curiosity. The tracing was normal except for first degree heart block. The PR interval was 0.24 second. First degree heart block of this magnitude usually means myocardial disease. The patient was

given grain 1/50 of atropine to diminish the effect of vagal tone. A second electrocardiogram showed a PR interval of 0.22 second. A ballistocardiogram was completely normal. The latter finding indicates that the first degree heart block was probably a variation of normal and does not indicate significant myocardial impairment.

Right bundle branch block is sometimes a congenital abnormality and does not in itself indicate heart disease in many instances. The ballistocardiogram would be helpful in these cases to determine whether or not the block actually represents serious heart disease.

2. MODERATE VALUE CASES

In acute myocardial infarction the electrocardiogram is most valuable. However, it takes several days in some instances for the electrocardiogram to exhibit a diagnostic pattern. *The ballistocardiogram is abnormal in practically all cases of myocardial infarction, even in the early stages.* The objective evidence so obtained helps support our clinical diagnosis until the electrocardiogram gives us confirmation. This abnormality is represented by a low J peak and early M configuration as is seen in the anginal syndrome. The ballistocardiogram in myocardial infarction does not show a specific or diagnostic pattern as we find with the electrocardiogram. However the ballistocardiogram is of definite prognostic significance. In many cases the electrocardiogram returns to normal and in a few cases the ballistocardiogram also returns to normal. A normal ballistocardiogram in the late post-infarction state is a favorable prognostic sign.

In active rheumatic carditis the ballistocardiogram is helpful but more research is necessary in this field. Shallow I nadirs and prominent L peaks exist in the presence of acute rheumatic carditis.

The ballistocardiogram is useful in differentiating ordinary essential hypertension from hypertensive heart disease. Early M configuration with a prominent K nadir is the usual finding.

Among older subjects, abnormal tracings are very common and do not necessarily indicate serious heart disease. A normal ballistocardiogram in an elderly person may be considered a favorable prognostic sign.

3. QUESTIONABLE VALUE CASES

In cases of obvious, serious heart disease the ballistocardiogram is always grossly abnormal and of little value. In valvular disease (except aortic insufficiency or aortic stenosis) the ballistocardiogram is of little value. The stethoscope is the instrument by which one makes this diagnosis. Cases of mitral stenosis have been reported in which there have appeared prominent headward waves preceding the H wave which is due to a hypertrophied left auricle. In cardiac arrhythmia, the electrocardiogram still reigns supreme. Occasionally the ballistocardiogram is helpful as in the following case:

Case 4. A 40 year old, married female had no complaints except for occasional bouts of palpitation and slight dyspnea. Physical examination including fluoroscopy was normal. Electrocardiogram showed a regular bigeminy due to unifocal ventricular premature contractions. The ballistocardiogram showed normal complexes for the normally conducted beats and abnormal complexes for the premature contractions (Fig. 3). The abnormality of

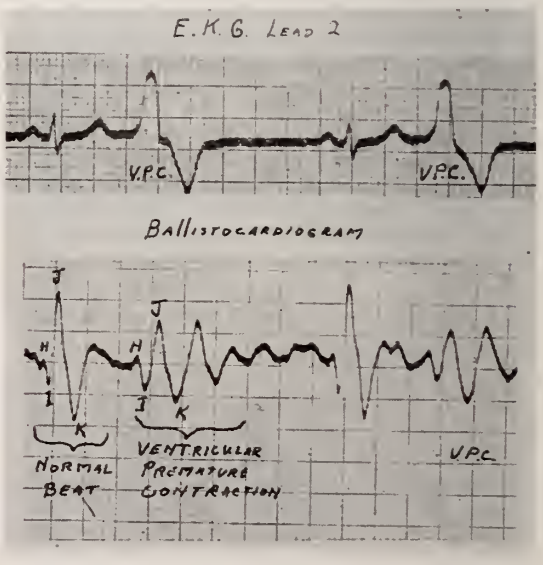


Figure 3. Case 4. Patient is clinically normal. Electrocardiogram: Bigeminy due to regular unifocal ventricular premature contractions. Ballistocardiogram reveals normal complexes for the normally conducted beats and widened complexes for the ventricular premature contractions. The difference in the time of systole, i.e. H to K time, between the normal and ectopic beats, is 0.07 seconds. The difference in the QRS interval on the electrocardiogram is 0.08 seconds.

the premature contractions is due to the fact that ventricular filling is incomplete at the time of the contractions and that conduction from the premature focus is delayed. This is reflected in the increased H to K interval which is 0.17 seconds for the normal beats and 0.24 seconds for the abnormally conducted beats. As a result of the ballistocardiogram findings, it is reasonable to assume that this patient is not suffering with any serious myocardial disease.

The ballistocardiogram presents no specific pattern in cases of congenital heart disease except in coarctation of the aorta. Here we find diminished or absent K waves. After operation for this condition K waves have been found to appear.

The ballistocardiogram has also been used in chronic pulmonary disease and in neurocirculatory asthenia. Further work is required in these fields.

COMMENT

The ballistocardiogram is a useful instrument in cardiac diagnosis and should be included with the electrocardiogram in the clinical diagnostician's armamentarium. However it will not give a rubber stamped diagnosis. It is no substitute for a good history, complete physical exam, and a careful workup and evaluation of findings. The ballistocardiogram will never supplant the electrocardiogram. Rather it will complement it and help to show abnormalities which the electrocardiogram fails to reveal. At the same time the electrocardiogram should act as a check rein on the ballistocardiogram. While serious heart disease may exist in cases where the ballistocardiogram is abnormal and the electrocardiogram is normal, the prognosis is usually worse when both are abnormal. An abnormal ballistocardiogram, especially among older subjects, does not necessarily mean an unfavorable prognosis. When effective treatment for arteriosclerosis becomes practical, such treatment will undoubtedly achieve better results as a preventive measure or in the treatment of the early stages. Early diagnosis in coronary artery disease will then be even more important than it is now. At present the ballistocardiogram is the best instrument available for the early detection of this condition. We must be careful in interpreting ballistocardiograms until more is known about the science of ballistocardiography. While we are learning, it might be better to under-interpret rather than over-interpret the tracings.

SUMMARY

1. Ballistocardiography is a means of measuring quantitatively and qualitatively the mechanical action of the heart by means of recoil waves caused by the heart action.

2. Precautions in preparation for taking a ballistocardiogram are noted.

3. Case reports are presented which indicate specific instances in which the ballistocardiogram is of value in cardiac diagnosis.

4. The ballistocardiogram should be used together with the electrocardiogram in a routine cardiac "workup".

5. The ballistocardiogram is a very sensitive instrument which will become invaluable in the early detection of coronary artery disease when effective and practical therapy for this condition is discovered.

The author wishes to thank Dr. August J. Pacini of New York City for his helpful advice and hints in the preparation of this manuscript.

326 Richmond Avenue

SOCIETY FOR THE PREVENTION OF ASPHYXIAL DEATH, INC.

An interested donor has offered to donate a copy of the *Art of Resuscitation* by Paluel J. Flagg, M.D., to the first hundred physicians who become members of the Society for Prevention of Asphyxial Death, Inc., after publication of this notice. Applicants should communicate with Dr. E. H. Zabriskie, Secretary, at 2 East 63d Street, New York 21, N. Y.

UNUSUAL FRACTURE—DISLOCATION OF THE ANKLE

FRED I. SCHWARTZBERG, M.D., Paterson, N. J.

In 1947 Bosworth* described an unusual type of fracture-dislocation of the ankle joint hitherto unrecognized or described in orthopedic texts. Open reduction in the five cases reported by him showed the fibula to be caught behind the tibia, remaining strongly fixed there and replaced to its normal anatomic position only by prying it away from the tibia.

During the past three years, two such cases have come to my attention. Neither of these could have been effectively treated except by open reduction. Because of the importance of open reduction in proper treatment, the early identification and recognition of this type of fracture is essential. Bosworth* has pointed out that if the situation is not recognized and corrected at the time of injury, the resulting instability of the ankle joint can be relieved only by fusion.

CASE ONE

A 42 year old male was admitted to the hospital following a fall on icy pavement, at which time he "twisted over" on his left ankle. X-rays on admission show a trimalleolar fracture of the ankle joint with posterior dislocation of the foot. See figure 1A. Under Pentothal Sodium[1] anesthesia, the foot was manipulated and the deformity clinically reduced, with an audible snap. A long leg cast was applied and review x-rays were made. See figure 1B. Although these showed apparent re-



Figure 1A. Case 1. Antero-posterior view of the ankle on admission. Note the completely deranged ankle joint. The posterior position of the fibula is not obvious.



Figure 1B. Note the poor reposition of the talus and the posterior displacement of the fibula.

* Bosworth, David: Journal of Bone and Joint Surgery, 29:130 (January 1947).

1. Pentothal is the Abbott Laboratories trade name for a brand of thiopental.

duction of the dislocated foot, the ankle mortise was not perfectly restored. The lateral view shows the posterior position of the distal end of the proximal fragment of the fibula. A second manipulation was attempted without improvement. The patient was returned to his room. In spite of the reduction of the dislocated foot and the plaster immobilization there was little, if any, relief from pain. Large doses of analgesics were required.

Through a lateral incision, the lower shaft of the fibula and the external malleolus were exposed. The distal end of the proximal fragment was fixed behind the tibia and had to be pried away with a periosteal elevator to be released. The internal malleolus was also exposed, and internal fixation accomplished with two vitallium screws. See figure 1C. There was no ultimate functional disability.

CASE TWO

A 51 year old female injured her left ankle while riding as a passenger in the front seat of a car. On admission to the hospital, the ankle showed marked deformity, with the foot displaced posteriorly. X-rays on admission showed a trimalleolar fracture with posterior dislocation of the foot at the ankle joint.

The ankle was manipulated under Pentothal Sodium[1] anesthesia and traction utilized on the foot in equinus. A sense of reduction of the dislocated foot was felt and the appearance of the ankle was normal clinically. A short leg cast was applied and review x-rays were taken. See figure 2A.

Study of the film shows the incomplete restoration of the ankle mortise as well as the posterior position of the proximal fibular fragment behind the tibia. Confronted with this situation and recognizing the analogy of the case above described (the characteristic x-ray findings coupled with the clinical picture of unabated pain following manipulation), I decided against a second manipulation. At open operation through a lateral incision, the strongly fixed position of the fibula behind the tibia was readily demonstrated. The tibio-fibular ligament was torn and shredded. With a periosteal elevator the proximal fibular fragment was pried out of its position, accompanied by a snap. A vitallium screw was used for internal fixation and supplemented with a cast to the knee. See figure 2B. The internal malleolus required no internal fixation in this case. Complete functional recovery of the ankle has now been obtained.



Figure 1C. The ankle mortise is completely restored. Internal fixation was secured by two vitallium screws.



Figure 2A. Case 2. Antero-posterior view through the cast shows the fixed posterior displacement of the fibula.



Figure 2B. Complete reduction by open operation, fibula pried out and one screw used for internal fixation. Note the accurate reposition of the talus under the tibia and the normal appearance of the ankle mortise.

Bosworth* has explained the mechanism of this type of fracture-dislocation by stating that the external malleolus does not break off until the foot is completely displaced posteriorly and the fibula is behind the tibia. This would of necessity be preceded by a rupturing of the tibio-fibular ligament at the ankle, and can be seen when the area is exposed.

One should be on guard for a possible complicating factor when there is practically no relief from pain following reduction of the dislocated foot and immobilization in a cast. In both of these cases, morphine was required at four-hour intervals in spite of the plaster immobilization and the apparently improved clinical appearance of the ankle. The opiate was significantly less needed as soon as open reduction was completed.

SUMMARY

Two unusual cases of ankle fracture are presented in which the fibula is fixed behind the tibia. In all fibular fractures (Pott's fractures) with posterior dislocation of the foot, a careful study of the x-ray films should be made in search of evidence of this complicating factor. Closed manipulation in this type of case is of no avail. It should be treated by open reduction at once. Failure to do so will result in a painful, unstable ankle joint which can then be treated only by arthrodesis.

522 Broadway

REGISTRY OF EDITORIAL ASSISTANTS AND ARTICLE COLLABORATORS

A clearinghouse service on editorial assistants and medical article collaborators to assist in the preparation of papers for meetings, publication or clinical demonstrations is being established. Technicians qualified to assist in editing explanatory or sound tract material in conjunction with professional motion pictures are included. Information will be available to *all* members of the medical profession on request. Doctors who know of competent medical writers and editorial assistants are asked to forward names and addresses of qualified collaborators to Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas.

EDUCATION: MEDICAL AND OTHERWISE*

George H. Lathrope, M.D., Morristown, N. J.

We have been engaged for the past quarter century in a bitter controversy over socialized medicine. This has been waged with such acrimony and mud slinging that we have been blinded to the real crux of the problem. We fail to see the woods for the trees. The question of federal regimentation of the profession has been grafted on, and beclouds the real issue which is, primarily, dissatisfaction on the part of the public, or consumer, with the services rendered by the medical profession, or dealer. Keep that in mind. The secondary issue of federal control was imposed on this controversy by our social elevators in Washington, for whom it is a golden opportunity to drive an important wedge of socialism into our national structure. This subsidiary problem has come to hold the center of the stage and serves to confuse and fog the picture, and likewise draws our attention away from the main issue.

About the turn of the century, medical science began to take enormous strides which have continued to the present, accumulating a mass of new information impossible for any one person to absorb. While the new discoveries revealed some remarkable therapeutic measures of a specific type, most of them were concerned with diagnostic procedures. The doctor's office began to be cluttered with machinery of one sort and another to facilitate diagnosis. The public, while impressed by all these new gadgets, did not altogether fancy having to pay for them. Nor do they now accept whole-heartedly the extensive and expensive investigation which every illness appears to demand. They complain of the high cost of medical care.

Then for various reasons, partly because of better financial returns, the profession turned to the specialties; and, with the new diagnostic instruments, new specialties developed.

The public complain, and with reason, that they cannot get a doctor to take care of simple ailments; that the doctors are all specializing, and patients are shunted around from one specialist to another without knowing what it is about or getting anywhere. They complain that doctors will not go out at night, that they can hardly get one in the day time, and when he does graciously consent to come around he is too busy to give them more than five or ten minutes of his time; he is, or pretends to be, in a vast hurry. These and other similar criticisms have grown as the century has progressed. As we doctors seemed to be doing nothing about it, small wonder that the consumer welcomed with cheers the quack remedial measures of a socialist minded coterie in government circles who proposes to take the producer by the throat and tell him how and what he is to do.

This then is the problem—a dissatisfied public with the added threat of government intervention.

In part the answer is educational.

A wise philosopher of the last century said: "Work and learning were made for life, not life for work and learning." In other words the kind of life one leads is the all important thing—work and study are only parts of it.

The process of living bears three implications.

1. We must live in the world at large and know something of its peoples and its history, what is going on, and why.

2. We must live with our neighbors, which implies compromise, forbearance, and evaluation of our ideas about personal liberty.

3. We must live with ourselves—a factor in living which many neglect till too late to make satisfactory adjustment. We spend our early days in the practice of medicine under the compulsion of making a living and raising a young family. We have been intensively devoted for 8 or 10 years to acquisition of the knowledge of our chosen subject. Learning and work obsess all our time and thought and we forget or neglect the life around and ahead of us. We forget that life is the all important factor, that living broadly and wisely is the thing to be desired. Witness the plight of many a man retired at the age of 65, left with nothing to do and no interest to occupy him.

Whether we will or no, education is a life long process. We are constantly undergoing examination as we meet the daily incidents of

*Delivered by invitation at the Annual Meeting of The Medical Service of the Jersey City Medical Center, January 16, 1952.

practice and living. We make our mistakes; they can be useful and some one has said that "intelligence is the ability to profit by mistakes". Experience is a daily matter; reading newspapers and books, contact with people, helping to settle their problems as well as our own, meeting the daily tasks which may be trivial or suddenly loom large and into serious proportions.

Education consists in the storing up of that experience and with it and by means of it fitting ourselves to meet future exigencies: not only exigencies, but, more, to meet life and to make something of living—the more graciously the better. That is what we will need as we reach middle age and advance further toward what we hope will be a mellow evening of life.

So much briefly for self-education. Let us take a short backward glance at formalized education and its development. As Europe emerged from the so-called Dark Ages the church schools established by Charlemagne were gradually superseded in the tenth and eleventh centuries by the newly developing universities. These loosely knit institutions were, in the north, developed directly from the church schools, and thus in Paris and Oxford the chief interest came to be theology and the arts; while in the south, where the influence of the church schools was negligible, Bologna turned to the exposition of the law, Salerno to medicine, Montpellier to both law and medicine—and so on.

Basic education of those days consisted in study of the seven liberal arts comprised in the Trivium and the Quadrivium. The former embodied grammer, rhetoric and logic; while the quadrivium comprised arithmetic, geometry, music and astronomy. With these fundamentals a student might wander about from one seat of learning to another. Entrance to, and length of stay in, the universities was matter for the individual to determine. When he had absorbed what he wanted, or all he could, in one place he slung his pack on his back and went to another. Thus it might be possible for the student of curious mind to encompass in his life-time all knowldege as it existed then. To illustrate this system in the twelfth century the lives of Abelard and his disciple, John of Salisbury, are worth studying.

Out of this the universities developed into more formal institutions with their Chancellors and Masters and the conferral of degrees. The Arab and the Jew had already preserved a large part of what has come down to us from the Greek and Roman classics. Spain was the enlightened spot which kept burning through the Dark Ages the fires of learning, and European scholars flocked thither to acquire knowledge at the feet of the Moorish and Jewish teachers. Of these the names of Averroes, Avicenna, and Maimonides are familiar to all of us. The hour does not permit us to spend more time on this period. It is mentioned here to point out that formalized education, as we know it, began only a relatively short time ago. Slowly out of this start has developed the system we have today.

Jefferson gave a great impetus to education when he propounded the doctrine of education for all—and at public expense. Our public school system owes its origin to him.

Vannevar Bush, in *Modern Arms and Free Men*, points up the Jeffersonian system and makes much of it. A glance at his ideas is worthwhile. Jefferson visualized he says, elementary mass education at public expense; and then state supported education at the highest levels, open, without expense, to those who could qualify for it in competition. This plan, if carried out in full, would give an electorate educated at least in the elements, and a system through which leaders could arise, through selection, educated to the maximum degree, and supported by the state as they acquired background and skills to be employed in the professions for the public benefit.

Bush points out that Jefferson thus conceived a pyramidal system:

1. Elementary school for all.
2. High schools open to competitive examination.
3. Colleges on a like basis.
4. Universities at the top for the youngsters most highly endowed from every stratum of society, and supported independently of personal or family resources.

He points out further, that today, while elementary and high school education is fairly

covered by our public schools, the higher levels are, for the most part, open only to the individual with means to pay for them; opportunity for pure research is open only to a select few. Thus what Bush calls "equality of exposure" has been attained; but by no means equality of opportunity.

Bush then turns to medical education in particular, describes the early system of apprenticeship and pays tribute to the influence of the Hippocratic Oath as a means for stimulating high ethical standards. Modern medical education began with the work of Welsh, Osler and their confreres at Johns Hopkins, which led the way to the present day medical school allied with large hospitals. The Flexner Report (1910) was instrumental in establishing a satisfactory grading of medical schools and the ultimate retirement of most of those not in Grade A. Still, he adds, there are not enough men trained and there is no real equality of opportunity. Teachers are poorly paid and there are not enough good doctors to go around. The course is long and when men emerge the need for making a living keeps many, otherwise well fitted, from going in for research.

From this he argues for federal funds for scholarships, with lay, but not political control. He stresses the great need for research in biologic warfare, and asserts that advances in medical science have come, not so much from medical ranks as from chemists, biologists, physiologists, pharmacists, and even the dye industry. He takes a mild fling at us in saying that the gulf between the medical man and other professions is widened by the former's insistence on his prerogatives.

Impregnated, as Bush is, with the Jeffersonian ether—if I may paraphrase Boswell—he believes that young men of exceptional ability anywhere should be able to proceed to the highest level of medical education at public expense. He cites the Atomic Energy Commission, the Navy Department, and the Public Health Service as having made a beginning by research fellowships under contract with the universities; but warns of the inherent danger of an essential part of our university system coming under the control of a single individual. He recommends centralization within the federal government with the ultimate control of policy placed in the hands of a representative body of citizens. The National Science Foundation will do much, he thinks, if given a proper start.

Thus Mr. Bush. This review of a portion of his book is offered to show how intelligent laymen are regarding some of our educational problems, and not with the idea of submitting a finished plan nor one which we, necessarily, should approve. It reveals a trend of thought, and gives us something to ponder.

We are no longer in the twelfth century with Abelard and John of Salisbury and cannot hope to know all things. Accumulated knowledge today is far too vast. Particularly this statement is true for a highly specialized branch of knowledge like medicine. How then are we to plan education for the immediate and distant future? Ground work should be laid in the humanities—Greek and Latin, translated or in the original, history, literature, philosophy, et cetera, without which no one can pretend to any degree of culture. Specialization should not be started in high school or college. That period should be spent in laying a wide and comprehensive foundation for future extension of knowledge. Only thus can one at middle age be ready for further deepening his acquaintance with men and with life; only thus can he begin to enjoy the benefit of an early foundation laid with the thought of future development.

This early education then should be horizontal, spreading out over those areas which may become increasingly important as life and years increase. Then with entrance into the university comes the time for vertical education, and from the horizontal field is chosen that subject which the student has selected for his life work. Let us say this is medicine. Again in this vertical and circumscribed field the early studies should be on a horizontal plane involving as far as may be the entire scope of medical knowledge. It must be understood that horizontal education can be only, or relatively, superficial. It lays the foundation for future work in the vertical area of the subject or subjects one selects. It gives the student oppor-

tunity better to select his chosen subject, and this selection should be postponed to a period when he is going to deal with it maturely and wisely.

The horizontal education in medicine should extend both through medical school and hospital internship; it should involve three or more years in the general practice of medicine before specialization is begun. Indeed some years in general practice are a *sine qua non* of a good medical education, for in that milieu the student learns much that cannot be taught in college or hospital ward.

The practice in the past quarter century has been quite the other way. Specialization seemingly cannot start too soon. The college course is filled with premedical subjects to the exclusion of broader, more cultural courses, and the young medical student is urged by his professors to select his specialty early, to direct his internship so far as possible along that line, and to begin its practice at once he leaves the hospital. Thus there is launched on an unsuspecting public an intensified specialist, but a poorly educated doctor with a vest-pocket horizon.

My plea is for a broad, truly cultural background of study; broad in its general and humanistic implications; broad even in the narrower sense of medicine. The physician must be not only and solely a doctor, he should be an active member of the community. Human beings are the material of his work. They are not mere vegetative organisms. It is not enough simply to treat the physical defect which leads the patient into the physician's office. There is to every disorder a mental or emotional side which must be considered, neglect of which may easily thwart all effort at cure. The highly trained and intensified specialist misses much of this side of the patient; or, if he sees it, regards it as belonging to a specialty other than his own.

The "doctors of the old school" were men of the cultured type, men of medicine, real citizens and often leaders in community affairs. There is much complaint that this useful type of man has vanished; that the family doctor is disappearing and that the medical field is wholly taken up by specialists. That there does exist a plethora of so-called specialists is obvious to any experienced individual who observes the field of medicine with a degree of detachment. Also it is obvious that many of these specialists are poorly trained in that they are unable to evaluate anything outside their own field, and further, that they often mistakenly involve under their own specialty cases which do not belong there. They are prone to see everything through glasses tinted with the shades of their own narrow line of work, and each case has a varying hue of yellow, red, or blue according to the color glass the doctor wears. This is not a healthy situation, either for the public or for the profession. It is not good medicine.

Already there appears a trend in the other direction. This is as it should be. But the effort to popularize general practice has only begun. The general practitioner is the heart and core of medical service. In his keeping lies the health of the community at large. Furthermore general practice gives a training and develops insights that are invaluable to any physician, whatever his field, and can be acquired no otherwhere than in the daily round of visits which educate the doctor in the family life of his community and in the human side of medical problems. More than a few of our leading men are beginning to feel that a few years of general practice should be required before a man be recognized as fit for specializing. He would be maturer, have a broader, more humanistic point of view, and all the more sure that his chosen specialty is that for which he is really fitted.

These remarks are addressed to you because each of you here comes in contact with young men and women beginning or about to begin their medical careers. You are teaching students, or, as an attending, are in contact, more or less close as you choose to make it, with interns and residents; or young people come to you for advice whether or no to take up medicine and, if so, how to go about it. Your responsibility in the matter is definite whether you will or no. You can do much to guide these young lives toward better, higher education, toward making of themselves wiser doctors, broader and better balanced men and

women who at middle age will have attained a worth while place not only in their chosen profession, but in the life of their community. There is choice: the streamlined type of education on the one hand, premedical and medical, with the direct plunge into a specialty on completing internship or residency. But there is the slower approach, with four years of college acquiring the fundamentals of a broad and cultural training; then the medical course and hospital internship or residency, and finally three or four years of general practice. The first type of training we have seen much of in the past quarter century, and it brings before the public a large number of specialists who from experience and training are but poorly qualified. The other training pattern produces a more thoughtful, maturer physician, and by the time he has decided to take up a narrow line of work he is better fitted by his training and his experience in general medicine to know where his own special proficiencies and interests lie.

Specific recommendations then may be offered:

1. Minimize so-called premedical courses, and make education preliminary to medical college as broad as possible and in the horizontal plane.
2. Let the vertical education begin in the medical school, itself on a broad scientific basis.
3. Reserve specialization till the degree is won, hospital internship completed, and a trial period undergone of three or more years in general practice.
4. Exception should be made to this plan only for certain brilliant students whose aptitude for research has been demonstrated during their student years, and who then pass rigid tests. These scholars should be subsidized with fellowships of value sufficient to keep them in security.
5. The federal government, if it is to help in education, should accept this last responsibility under the control of lay boards free from all political influence.

The questions raised here are, of course, highly controversial; but are posed in the hope of provoking thought and discussion. There are definite defects in the medical practice of today. Recognition and correction of these defects lies in large part with the profession itself. What are we going to do about it?

In closing let me repeat the words of Herbert Spencer used in the opening part of this address: "Work and learning were made for life, *not* life for work and learning".

20 Elm Street

EPIDEMIC HEMORRHAGIC FEVER

The Office of the Surgeon General (Army), has recently released information concerning epidemic hemorrhagic fever which has affected U. N. troops in Korea. This disease, first encountered by the Japanese in Manchuria in 1939, is believed to be caused by a filtrable virus or rickettsial organism. It occurs most frequently in May, June, October and November, and is prevalent in areas along river banks and in swampy marshlands. Its seasonal incidence coincides with the period of greatest reproduction of a mite believed to be the insect vector.

The disease affects the peripheral circulation with stasis, hemorrhage, and transudation, especially in the capillaries, which show endothelial damage. The kidneys, liver, right atrium of the heart, adrenal medulla, and ciliary body of the eye are frequently involved, and subarachnoid hemorrhage is occasionally seen.

The incubation period is 3 to 30 days. Onset is sudden with chills, fever, severe headaches, anorexia, nausea and vomiting. Temperature may reach 104 degrees on the third day, and falls to normal or below by the fifth or sixth day, following which the most serious manifestations of the disease may occur. There is a petechial or macular rash on the third day. Shock, oliguria or anuria may ensue, and painful swallowing is common. Recovery is usually in about two weeks.

There are no diagnostic laboratory findings. There may be anemia, leukemoid leucocytosis and eosinophilia. There is also a fall in the platelet count. The Weil-Felix reaction is negative, but the Wassermann may be weakly positive.

Prognosis is poor if there is bradycardia and hypotension on the third day. Mortality rate averages 13 per cent.

There is no specific therapy. Antibiotics and convalescent serum from recovered patients have been helpful in controlling the febrile stage. There are no known residual effects. The best prophylaxis is good insect control.

TOPICAL ANTIHISTAMINE THERAPY IN ANO-GENITAL PRURITUS *

RITA S. FINKLER, M.D., Newark, N. J.

Feinberg and Bernstein[1] have demonstrated the usefulness of antihistaminic ointment in the symptomatic treatment of pruritic dermatoses. Since then the value of topical administration of antihistaminic drugs in the treatment of itching dermatoses has become firmly established.

Findings with the histamine antagonist Thephorin† in the form of a 5 per cent ointment were first described by Shelmire.[2] He reported 305 patients suffering from a variety of pruritic dermatoses in 76 per cent of whom good results were obtained.

These favorable findings and similarly encouraging results more recently reported with Thephorin Ointment‡ by Laymon and Schmid,[3] Flower,[4] Wooldridge and Joseph,[5] and by Waldriff[6] *et al.*, prompted us to study its usefulness in a group of women with ano-genital pruritus. Pruritus vulvae and ani often become chronic, cause untold annoyance and embarrassment to the patient and frequently account for "nervousness" and sleep disturbance. Any medication which holds promise for better relief than the measures employed in the past deserves consideration.

PROCEDURE AND RESULTS

Every patient, reporting to our clinic or to the author's private office with the chief complaint of pruritus vulvae, pruritus ani or both, is given a thorough physical examination. A pelvic examination is accomplished for all married women. Every effort is made to detect any systemic disease which might account for generalized or local pruritus. The emotional state of the patients is also carefully considered.

Treatment is directed toward elimination of any underlying vaginal, rectal or systemic pathology. It has been our experience that the correction of cervicitis, vaginitis, rectal fissures or hemorrhoids, diabetes and hematologic or renal disease rarely relieves the patient of her pruritus. Similarly, psychotherapy only seldom achieves the desired results.

This paper describes our clinical experience in 57 patients with ano-genital pruritus with no demonstrable underlying pathology or in whom the aforementioned corrective measures were ineffective.

The age of these women ranged from 16 to 62 years with an average age of 38 years. Duration of their ailment was from six months to six years. In most cases there were various types of dermatoses extending occasionally to the thighs and sacral region. Most of the patients had previously used antipruritic ointments or lotions with poor to negative results.

We used Thephorin Ointment‡ in a carbowax base and a vanishing cream base, both in a 5 per cent concentration. The former is commercially available and the latter was prepared for experimental purposes to determine whether the vanishing cream type base had any advantages over the material in the carbowax base.

According to our original plan, each patient was to be given a supply of Thephorin Ointment,‡ either in the vanishing cream or the carbowax base, sufficient for a two weeks' trial. At the end of this period, patients were to report for re-examination. At that occasion, treatment with the other medication form was to be prescribed for two weeks. At the end of this second trial period patients were to be given a choice of the two preparations.

However, for reasons beyond our control, only 37 women used both ointments according to this plan. Seventeen employed Thephorin† in the vanishing cream base and three Thephorin‡ in the carbowax base, without being changed from one ointment form to the other. The following table records the results obtained in these 94 trials:

* From the Department of Endocrinology, Newark (N. J.) Beth Israel Hospital.

† Roche brand of phenindamine.

‡ Thephorin Ointment in vanishing cream and in carbowax base was generously supplied by Dr. Leo A. Pirk, of Hoffmann-La Roche, Inc., Nutley, New Jersey.

1. Feinberg, S. M., and Bernstein, T. B.: Journal of the American Medical Association, 134:874 (July 5, 1947).
2. Shelmire, B.: Postgraduate Medicine, 4:443 (November 1948).
3. Laymon, C. W., and Schmid, J. F.: Annals of Allergy, 6:636 (December 1948).
4. Flower, A. H., Jr.: North Carolina Medical Journal, 10:476 (September 1949).
5. Wooldridge, W. E., and Joseph, H. L.: Archives of Dermatology and Syphilology, 60:390 (March 1949).
6. Waldriff, G. A., Davis, J., and Lewis, G. M.: Archives of Dermatology and Syphilology, 61:361 (September 1950).

RESULTS OF TREATMENT WITH THEPHORIN OINTMENT IN 57 PATIENTS WITH ANO-GENITAL PRURITUS

	No. of Trials	Complete Relief	Partial Relief	No Relief	Worse	Incidence of Success
Preparation						
5% Thephorin† in vanishing cream	17	3	13	1	.	94.1%
5% Thephorin† in carbowax	3	1	1	.	1	66.6%
Both Preparations:						
5% Thephorin† in vanishing cream	37	5	29	1	2	90.9%
5% Thephorin† in carbowax	37	4	25	6	2	78.3%
Total	94	13	68	8	5	86.0%

In grading relief as "partial" or "complete", the patients' subjective appraisal was the main means for judging improvement; but objective findings, such as subsidence of cutaneous lesions, were also used as criteria. As is seen, the incidence of success in the patients who used both preparations was 91 per cent with Thephorin† in the vanishing cream base and 78.3 per cent with the ointment in the carbowax base. If all trials with the salve in the vanishing cream base on the one hand and in the carbowax base on the other are grouped together, the incidence of success was 92.5 per cent for the former material as compared with 77.5 per cent for Thephorin† in the carbowax base.

In most cases, relief was only partial. Discontinuance of medication frequently resulted in recurrence of the pruritus in its original intensity, as must be expected with any symptomatic treatment. Therefore, periodic use of Thephorin Ointment‡ was often necessary. However, in some cases, the relief achieved after a few weeks of therapy was permanent and did not require further treatment.

DISCUSSION

The data presented suggest that slightly better results are obtained in ano-genital pruritus with Thephorin Ointment‡ in the vanishing cream base. However, since the series of cases is small, and since the assessment of improvement is predicted mainly on a number of subjective factors, the question of superiority of one form over the other could not be determined with certainty. Indeed, the difference of results recorded has hardly any statistical significance. There is no doubt, though, that more than three out of each four patients derived some degree of relief of their pruritus from Thephorin Ointment.‡ These findings are in good agreement with those of Waldriff[6] *et al.*, who reported that 53 of their 67 patients with ano-genital pruritus were improved by Thephorin Ointment,‡ an incidence of success of 79 per cent.

Results in our series were superior to those which attended the use of other antipruritic ointments and lotions. Frequently we observed the disappearance of scratch marks and the subsidence of dermatitis under the influence of Thephorin Ointment.‡ As Shelmire[2] pointed out, if the pruritus is controlled further traumatization from scratching is prevented and this leads to healing of the lesion. This, in turn, is attended by alleviation of the pruritus.

SUMMARY AND CONCLUSIONS

Ointment preparations containing 5 per cent Thephorin‡ were evaluated in 57 women with ano-genital pruritus. In 37 patients, two medication forms were tried in succession which differed in the composition of the ointment base. Of these women 91 per cent derived benefit from Thephorin† in a vanishing cream base and 77.5 per cent from Thephorin in a carbowax base.‡ This suggests, but does not prove, the superiority of the material in the vanishing cream base. In the remaining 20 patients, either of the two ointment preparations was used, but they were not changed from one to the other.

It is concluded that Thephorin Ointment‡ is a very useful agent in cases of ano-genital pruritus. Gratifying relief of itching was obtained in over 75 per cent of the patients studied.

35 Leslie Street

HEART DISEASE AS A COMPLICATING FACTOR IN SURGICAL PROBLEMS *

FRANKLIN C. MASSEY,† M.D., Ardmore, Penna.

Precision in diagnosis is of utmost importance in assessing pre-operatively the patient with a complicating cardiac problem. The assumption of anesthesiological and surgical risks obviously depends on the accuracy of estimating the basic status of the cardiovascular system. Further, it is the responsibility of the internist-cardiologist to discourage surgical intervention if the situation in his opinion turns out to be primarily cardiac in origin.

Certain special knowledge of the technical surgical procedure is helpful for the clinician to possess: (1) anticipation of probable blood loss, (2) appreciation of the amount of trauma (but do not mention this to the surgeon!) endured, (3) an understanding of the structures involved and (4) estimation of the length of the particular operative performance. These four factors form the basis for estimation of the stress of the surgical procedure itself.

ANESTHETIC-OPERATIVE PERIOD

Acquaintance with the vagaries of the contemplated anesthetic agents and familiarity with the events of the anesthetic-surgical period are also valuable assets. Pertinent thumbnail generalities it is well to keep in mind relative to these include the following:

Cyanosis in the problem under discussion here, rarely is cardiac in origin. It usually is due to faulty gaseous exchange and is reversible on institution of proper corrective measures.

Disturbances of cardiac rhythm are more likely to occur with the less able anesthesiologist, although it is immediately apparent that the advent of disturbed cardiac rhythm does not necessarily imply incompetency on his part.

With surgical situations (postoperatively), hypotension and tachycardia are much more likely to be traceable to peripheral vascular collapse (shock) than to heart failure.

Good anesthesia should simulate normal sleep and does not endanger the patient's welfare. A corollary to this is that the services of a competent anesthesiologist are far more important than the type of anesthetic agent used. Hypoxia must be avoided at all costs and diastolic hypotension is anathema. Epinephrine should be avoided, since it tends to facilitate the onset of undesirable disturbances of cardiac rhythm.

CARDIAC EVALUATION

When evaluating for surgery the patient with organic heart disease, it is well to remember that if the individual's functional capacity was such that ordinary physical exertion was tolerated acceptably, then anesthesia and surgery will produce comparatively no greater amount of stress during the operative period. There are two cardiac exceptions to this generalization: (1) coronary artery disease and (2) syphilitic heart disease.

Coronary disease is a rather strong deterrent to all but imperative surgery. Severe angina, coronary insufficiency and progressive occlusive occlusion are definite caution signals. Acute myocardial infarction is an *absolute* contra-indication. The subtle nature of coronary arterial disease is irritating enough, without taking chances on individuals manifesting the disease overtly.

Heart failure can be considered an absolute contra-indication to surgery in that, under most circumstances, it is alleviable in a time short enough to permit postponement of even emergency surgery. Since it is possible to digitalize rapidly by use of parenteral preparations, it is folly to assume the tremendous mortality risk incurred by premature surgical intervention. Adjuvant anti-congestive failure therapy also facilitates proper pre-operative readying of the patient. Even if chronic heart failure has been present, if it is possible to correct it by

* Presented March 12, 1952, at St. Michael's Hospital, Newark, as a lecture in the course, "Cardiology for the General Practitioner", and also under the auspices of the New Jersey State Department of Health. Also presented April 17, 1952, before the Morris County Medical Society, at the Chilcott Laboratories, Morris Plains.

† Associate in Medicine, the Hahnemann Medical College and Hospital, Philadelphia, Penna.

intensive therapy, the patient then can become a surgical candidate, albeit a greatly "rated" risk.

Heart *disease* must be distinguished from heart *failure*. Such precision in diagnosis is re-emphasized in the instance of syphilitic aortitis (or syphilitic heart disease in general). Coronary ostial stenosis is a dynamic menace and is especially lethal in the company of spinal anesthesia.

Of the mechanismal disturbances, complete atrioventricular block (especially if complicated by Morgagni-Stokes-Adams episodes) seems to be the most hazardous, to the point of constituting practically an absolute contraindication to operation.

Atrial fibrillation would seem handled best by pre-operative digitalization despite the benignity of the functional status and without especial regard to the ventricular rate.

IMMEDIATE POSTOPERATIVE PERIOD

Anticipation of probable complications is the hallmark of the internist-cardiologist's success in managing the acute postoperative problems arising because of the complicating heart disease. Immediate recognition of suggestive signs coupled with prompt therapy ordinarily results in a favorable outcome.

Assessment of the operative urgency contrasted with the implications of the cardiac lesion, is *the* question in "Heart Disease As a Complicating Factor in Surgical Problems". Fundamentally, it is resolved by employing a combination of technical knowledge, logic in reasoning, sound judgment and positive action.

212 Williamsburg Road

MICROORGANISMS IN SYMPATHETIC OPHTHALMIA

Writing in the November 1951 *Archives of Ophthalmology,* E. Schreck of Heidelberg, Germany, summarizes histologic and experimental studies on sympathetic ophthalmia. In Type I of this disorder the seat of irritation occurs in the lens, iris and ciliary body of the exciting eye, and proceeds as a migrating perivasculitis of the retina and the optic nerve. There is an analogous migration of a periangiitis into the sympathizing eye which progresses as a migrating perivasculitis of the retina, and leads to an anterior uveitis. In Type II there occurs in both the exciting eye and the sympathizing eye an anterior and posterior uveitis connected by a continuous specific migrating perivasculitis and perineuritis along the posterior ciliary vessel and nerves, and along the vessels of the optic nerve. Further studies suggested that a specific microbiologic agent is responsible for the changes of sympathetic ophthalmia.

The author describes experimental data in which he says that he has isolated the microorganisms responsible for this disease by passage through chicken eyes, and by cultivation on the chorioallantoic membrane of chick embryos. He concludes that these microorganisms exist as a harmless saprophyte in the conjunctival sac, its epithelial cells, in the adventitial cells of the conjunctival and episcleral vessels and in the vessels of the limbal arcade. This organism becomes pathogenic only when it comes in contact with uveal tissue, which occurs when the corneoscleral barrier is broken down, as after a penetrating injury, operation, or perforating malignant intraocular tumor.

Inoculation of the lens with this organism produces Type I sympathetic ophthalmia, while invasion of the uveal tract produces Type II.

The exciting organism appears to be related to the Rickettsial group of microorganisms, and hence sulfonamides and penicillin are of little therapeutic value. Contrariwise, these drugs may actually destroy bacterial flora, and permit the rickettsial-like organisms to multiply more rapidly. Thus, it may be worthwhile to try aureomycin, chloramphenicol, PABA* and PAS†, as well as continuing to use older, approved methods of treatment, such as early enucleation of the suspected eye.

* Para-amino Benzoic Acid.
† Para-amino Salicylic Acid.

STATE ACTIVITIES

TRUSTEES' MEETING

APRIL 6, 1952

A regular meeting of the board of Trustees was held on Sunday, April 6, 1952, at the Executive Offices, Trenton. The following is a summary of the principal actions taken by the Board at this meeting.

After discussion of the status of S-139—to establish a separate board of chiropractic examiners—recently passed by both Houses, a motion was adopted that a statement of the Society's position be prepared by a special committee composed of Dr. Sigurd W. Johnsen, Dr. Harrold A. Murray, and Dr. C. Byron Blaisdell, cooperating with Dr. Daniel Bergsma and Mr. Richard I. Nevin, and that the statement then be presented to the Governor, with a request for a conference.

At the suggestion of Dr. Johnsen, motions of approval for the following steps were adopted:

1. That all county society presidents be requested to contact county members, their families, friends and patients, to write or telegraph Governor Driscoll to veto S-139.
2. That the Woman's Auxiliary, at state and county level, be likewise contacted.
3. That the Society notify all cooperating agencies of this campaign and ask their cooperation.
4. That the special committee be granted authority to take such steps as seem necessary to accomplish a veto of S-139.

Approval was given to a reply sent by the President to a communication from the Board of Trustees of the A.M.A. in which they declared that because the matter involves a House of Delegates' ruling, the Trustees of the A.M.A. were powerless to honor the request of The Medical Society of New Jersey that duly elected delegates to the A.M.A. be permitted to serve out their terms. The A.M.A. Board, however, did extend an invitation to the sixth delegate to sit in the House as an observer. Dr. Johnsen wrote that he would extend the invitation, but that he did not believe the delegate would accept it.

The Board accepted a written report from the Acting Director of the Division of Motor Vehicles as to the procedure whereby M.D. license plates may be exchanged for regular license plates. It directed that the information contained in this report be made available upon request by members, with the proviso that such members be reminded that M.D. license plates are issued primarily for the furtherance of civil defense objectives—a fact which everyone should bear in mind.

A resolution honoring the memory of Joseph G. Coleman, M.D., was unanimously adopted and the Board stood for one minute in silent tribute.

Approval was given to a motion that the Society pledge active cooperation and support to the Council for Local Public Health Services in New Jersey.

With reference to the report of the Executive Committee of its regular meeting held on February 3, 1952:

The nomination of Mr. Arthur V. Lunn as a member of the Board of Governors of Medical Service Administration, to fill the vacancy created by the resignation of Dr. Lance, was approved.

Because of approval already given for the publication of a Directory in 1953, the Board approved a motion that no Official List be published this year (1952).

Approval was given to the Executive Committee recommendation to Medical-Surgical Plan that the proposal to provide payment to eligible physicians participating in the care of surgical cases be submitted by means of a questionnaire to all the Plan's participating physicians, for purpose of ascertaining their desire.

The Board approved proposed amendments to the Constitution and By-Laws, and recommended their adoption by the House of Delegates.

Approval was given to the revised program for the Woman's Auxiliary spring public relations conference.

Approval was given to the report of the Medical-Legal Liaison Committee, and to the suggestion that the Bar Association be requested to support the Society's endeavors to secure a veto of S-139.

With reference to the report of the Executive Committee of its regular meeting held on March 2, 1952, approval was given to the fol-

lowing as members of the Committee on Physicians' Placement: Dr. Greifinger, Chairman, First District; Dr. Jehl, Second District; Dr. Lloyd, Third District; Dr. Pieper, Fourth District; Dr. Suter, Fifth District.

Approval was given to the report of the Medical-Dental Liaison Committee.

A citation to be presented in conjunction with the celebration of the tenth anniversary of Medical-Surgical Plan was read and approved.

With reference to the report of the Welfare Committee of its regular meeting on March 2, 1952:

Approval was given to the recommendation that the Special Committee on the Medical-Dental School be permitted to cooperate with the committee of action sponsored by Rutgers University.

The Board approved of the report and recommendations of the Subcommittee on Legislation.

Approval was granted to a motion that the question as to whether or not county societies should include A.M.A. dues in their annual billing to members be placed before the House of Delegates.

The Board approved the recommendation that general practitioners who so desire may be identified as such in the classified section of the telephone directory by means of an "*" or an "X". The Board also approved the recommendation that physicians named in the classified section be listed under the heading "Physicians and Surgeons—Members of The Medical Society of New Jersey".

Approval was given to the action of the committee on the report of the Temporary Committee on the Chronic Sick.

The Board disapproved the recommendation favoring state aid to hospital nursing schools.

The Board approved the recommendation regarding appointment of consulting ophthalmologists to the State Department of Education, the Motor Vehicle Division, and all other such groups.

The Board approved a recommendation regarding "Good Breakfast Week".

Approval was given to the recommendation regarding the program of the Human Biological Defense Committee of Civil Defense.

The Board approved the recommendation that the Executive Officer investigate the possibilities of establishing medical-secretarial courses in high schools and junior colleges.

The Board disapproved the recommendation that the current Junior Health Hints be compiled in book form for distribution.

The Board approved in principle the proposed Code of Cooperation submitted by the Subcommittee on Public Relations.

Approval in principle was given to the 1952-53 program submitted by the Woman's Auxiliary.

The nominations of Carl K. Withers and Charles W. Barkhorn, M.D., as members of the Board of Trustees of Medical-Surgical Plan were approved.

The Board nominated Vincent P. Butler, M.D., for re-election to the Board of Trustees of Hospital-Service Plan.

The Board approved the appointment of Dr. Henry B. Decker as the Medical Society representative on the Conference Committee of the Middle Atlantic States Regional Conference, to be held in Philadelphia May 8, 1952.

The Board approved the recommendation of the Editor of The Journal that The Journal be made available to medical students at $1.50 per year providing each application be certified as coming from a *bona fide* student.

ACCOLADE TO DR. WATSON MORRIS

On March 5, 1952, Overlook Hospital honored its senior member, Dr. Watson B. Morris of Springfield, on his 50th year of service to mankind. The event was sponsored by the hospital's medical staff and took the form of a testimonial dinner at the Canoe Brook Country Club.

Since 1913—when the hospital was in its infancy—Dr. Morris, who is 74, has been on its staff. He is its senior member, having served on the medical staff until 1946, and since then on the consulting staff.

Dr. Fletcher I. Krauss of Chatham and Dr. M. G. Bensley of Summit, principal speakers, told of the old days of Overlook and commended Dr. Morris for contributions to the hospital. Dr. Cedric C. Carpenter of Summit, new president of the staff, gave Dr. Morris's background.

Dr. Morris, who has devoted much of his practice to surgery for the last 20 years, is active also at the Bonnie Burn Sanatorium, the Union County tuberculosis hospital. There, too, in 1950, he was honored with other staff

members at ceremonies observing his 20th year on the board, of which he is now president.

He was born in Utica, N. Y., and was graduated in 1902 from the Bellevue Medical School of New York University. After interning at Bellevue, he began his practice in New York in 1905. A year later, he became associated with the late Dr. George H. Cobb of South Orange and in 1910 he married Miss Susanne Smith of Maplewood and moved to Springfield, where they now reside.

He was president of the Union County Medical Society in 1934, and is now a member of its executive committee. He is also chairman of its emeritus and honorary membership committee. In 1936 he became a Trustee of The Medical Society of New Jersey and was its President in 1940.

From 1941 to 1948 he was chairman of the Board of Regents of the United States chapter of the International College of Surgeons.

Dr. Morris is a Fellow of the American College of Surgeons and a Founder Fellow of the International College of Surgeons.

SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY

The above-captioned Society has just completed 70 years of service to the families of New Jersey physicians. It is a unique helping-hand organization, founded in 1882, having as its purpose, the provision of *immediate* financial aid to those who had been dependent on a deceased member. It also assists living members disabled through illness or other misfortune by lending money without collateral and without interest. It even has facilities for assisting the widow or children of a deceased member who had previously exhausted his resources.

Each member who joins the Society prior to his 50th birthday, pays $1 each time another member dies. The total so accrued becomes a special fund for each death and 80 per cent of it goes immediately to the widow or next of kin. This averages slightly under $500 for each death. A doctor who joins the Society when he is between 50 and 55 years of age, pays $2 per death, and if he is between 55 and 60, (when he joins) he pays an assessment of $3 per death. The Society also has a Permanent Fund, now close to $100,000, the interest on which is used for special benefits, particularly to provide additional help to needy widows and orphans of ex-members.

Obviously, the more members the Society has, the greater the amount immediately available to the widow at the time of death. On the average, the Society loses 10 to 15 members per year by death, so the financial burden on any individual surviving member is never excessive.

For further information and for membership application forms, write to Dr. Charles G. Crane, Secretary, at 78 Farley Avenue, Newark 8, N. J.

CORRECTION: A.C.S. FELLOWS

A list of recently elected New Jersey Fellows of the American College of Surgeons, furnished by the A.C.S., was published in the March JOURNAL. The name of Carl E. Rothschild of Englewood was inadvertently omitted from the list as submitted to us. We publish this emendation and apologize to Dr. Rothschild for the omission.

NEW JERSEY SOCIETY OF CLINICAL PATHOLOGISTS

At the annual meeting of the New Jersey Society of Clinical Pathologists held in Atlantic City on May 19, 1952, the following officers were elected: President—Edwin H. Albano, M.D., East Orange; Vice-President—Thomas Rathmell, M.D., Trenton; Secretary-Treasurer—Robert Brill, M.D., Passaic.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, March 14, 1952, with DR. ANTHONY G. MERENDINO presiding.

The guest speaker was DR. BURGESS GORDON, President of Women's Medical College of Pennsylvania. His subject "Recent Advances in the Management of Chronic Pulmonary Diseases" was ably presented. The topic was of interest and importance, giving a clearer understanding of a new field of therapy.

The newest Red Cross film on Blood, showing the various phases from collection to its use on the battlefield, was shown to the Society by Mr. Joseph Hackney. Dr. Merendino announced that Dr. Joseph McGahn had been appointed Chairman of the Red Cross Drive Committee for the Society, and urged all members to lend every possible support to this vital cause.

The minutes of a special meeting of the Executive Committee, held on February 22, were read to the Society. There was considerable discussion and a divergence of opinion in regard to the following motion which had been approved by the Executive Committee:

"That the Executive Committee of this Society endorse the Emergency Medical Service Plan suggested by the A.M.A., whereby all calls received through the E.M.S. are taken by the physician on call. Further, that this duty be deemed compulsory for all members 45 years of age, or under, with no exceptions except for formal request, in writing, to the President of the Society, to be acted upon by the Executive Committee."

It was felt by some that this was properly a matter to be decided upon by the Society as a whole; some objected to the term "compulsory", while others, especially those members more directly affected by the plan, agreed that a purely voluntary plan was not entirely feasible. A recent A.M.A. survey of the E.M.S. Plans throughout the country showed that many societies had plans in which this duty was a required one. It was finally agreed that the motion would be proper if it were restricted entirely to emergency calls, and it was therefore moved that the original motion be amended to read:

"That it be a required duty for all members 45 years of age, or under, to make all emergency calls received in a 24 hour tour of duty." The motion was seconded and carried.

Dr. Holland reported that the present plan to take care of emergency calls would be effective and adequate if doctors would arrange for proper relief when they were off call or out of town. He stated that 124 emergency calls have been made since the plan has been in existence, and added that the new telephone directory in July would carry an advertisement outlining to the public the proper method of securing a physician in a true emergency.

DR. DUDLEY E. MACKEY of Hammonton was elected to Associate membership.

Dr. Gleason brought to the attention of the Society, two important proposed changes in the operation of the Medical-Surgical Plan. The first was a request that the Society go on record as approving a proposed program for the division of surgical fees in accordance with the proportionate services that have been rendered, i.e.; That both a surgeon and his assistant may render separate bills on the same patient, each for that portion of the service which he has rendered. It was brought out that even though this program had been approved by the A.M.A. and the College of Surgeons, it presented many possibilities for misinterpretation and for misconstruing its true purpose. It was therefore agreed that the motion for recommendation of this program be tabled, and that the Society take no action at this time.

The second was a request for the opinion of the Society in regard to a proposed unlimited income rider to be attached to the present Medical-Surgical Plan. It was stated that in order to attract large groups to the Plan, it would be necessary to include the executive group with incomes over $5000 at an additional premium. This would mean larger fees for physicians, but these fees will be fixed at approximately 50 per cent above present fees. The proposal as outlined, was viewed unfavorably, and it was the opinion of the Society that the rider plan be disapproved.

The following motion was made by Dr. McCracken, seconded and carried: "That the Medical Society of Atlantic County recommend the issuance of a permanent license to the Ellen Nursing Home, 1001 Tilton Road, Northfield, N. J."

Dr. Merendino announced, with sincere regret, the passing of another beloved and esteemed colleague, Dr. Edward Guion. The Secretary read to the Society a set of resolutions that symbolize our sincere sorrow and sympathy. It was moved and seconded that the resolutions be adopted and that they be inscribed upon the minutes of our Society.

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

A regular meeting of the *Burlington County Medical Society* convened at the Riverton Country Club on March 13, 1952, at 9:00 p. m. President T. B. DICKSON, M.D., officiated.

The scientific portion of the meeting consisted of sound films in color presented by The Armour Laboratories. One dealt with *The Therapeutic Use of ACTH in Human Disease.* The second, entitled *Tryptar,* described Armour's enzymatic agent for medical debridement.

During the business session a motion was unanimously passed that our County Society establish a fund for the purpose of financing the training in nursing of some worthy resident of Burlington County in a local institution of his or her choice.

This fund is to be known as the Burlington County Medical Society Nursing Scholarship. President Dickson was authorized to appoint a scholarship committee.

A regular meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on April 10, 1952, at 9:00 p. m. President T. B. Dickson, M.D., presided.

As is customary, the April scientific program was presented by our own members. The session included the following papers:

1. A Clinical Evaluation of Neomycin—Dr. John R. Wolgamot. Discussion by Dr. Perry S. MacNeal.
2. Open Reduction as the Treatment of Choice in Certain Ankle Fractures—Dr. Morris A. Robbins. Discussion by Dr. E. Vernon Davis.
3. Proctoscopy at the Burlington County Hospital —Dr. Luis E. Viteri. Discussion by Dr. Thomas J. Summey.

Each paper was well prepared and included slides or illustrative x-rays. The discussions were interesting and informative.

A short business meeting followed.

CAMDEN COUNTY

James P. Harbeson, III, M.D., Reporter

With Walter A. Crist, M.D., presiding, the regular monthly meeting of the *Camden County Medical Society* was held at the Dispensary Building on April 1, 1952.

A memoir upon the passing of Dr. John W. Stone was read by Dr. Swiecicki. The memoir was to be spread upon the minutes and a copy sent to Dr. Stone's family.

Dr. Ernest W. Clark was elected to honorary membership.

Dr. William T. Snagg introduced the speaker of the evening, Dr. I. W. Ginsburg, associate professor of Medicine at Temple University School of Medicine. His subject was "Venous Thrombosis and Pulmonary Embolism". Dr. Ginsburg gave a very thorough and interesting discussion of these problems and their modern method of handling such cases.

Following the scientific session, the Medical-Surgical Plan of New Jersey was discussed at length by Dr. Eynon who presented a series of resolutions, which were voted upon after considerable discussion by the members. Six resolutions were presented.

1. Be it resolved that the fee schedule of the Medical-Surgical Plan of New Jersey be adjusted to bring into equality the fees paid for medical and for surgical cases. Be it further resolved that the following considerations be applied to such adjustments.

a. Establishment of package fee schedule for certain medical diseases.

b. Adjustment of fee for the daily hospital visit and subsequent hospital visits on the same day to $5.00 each.

c. Remove the limitation of twenty-one days per contract year and the financial limitation per contract year.

2. Be it resolved by the Camden County Medical Society that this society is opposed to any removal of income limitations or to advancing the income limitation on Medical-Surgical Plan contracts.

3. The Medical-Surgical Plan of New Jersey has requested each county medical society of New Jersey to express its opinion upon their proposed plan to split the fee paid in surgical cases so that a portion of that fee may be paid by the plan to an assistant designated as such by the surgeon in charge. Be it resolved by the Camden County Medical Society that this society is opposed to the splitting of the surgical fee as suggested by the Medical-Surgical Plan of New Jersey.

4. Be it resolved by the Camden County Medical Society that this society request The Medical Society of New Jersey to advise some system of notification to the attending physician in regard to the income of the subscriber whom he may be attending. It is suggested that some definite marking be made on the subscriber's identification card as issued by the Medical-Surgical Plan of New Jersey to designate his income limit.

5. Be it resolved by the Camden County Medical Society that this society recommend to The Medical Society of New Jersey that the entire question of participation in medical-surgical insurance with the Medical-Surgical Plan of New Jersey be considered with a view to deciding whether The Medical Society of New Jersey should withdraw its participation and allow the Medical-Surgical Plan to sell pure indemnity insurance or whether there should be a return of the original purpose in the participation of The Medical Society of New Jersey with the Medical-Surgical Plan of New Jersey. Namely to provide help to the low income group in the payment of medical and surgical fees for catastrophic illness.

6. Be it resolved by the Camden County Medical Society that the foregoing preambles and resolutions be forwarded to The Medical Society of New Jersey for its immediate action.

The secretary was instructed to send telegrams to the Camden County Assemblymen, registering the Camden County Medical Society's opposition to Senate bills 139 and 28. The members were also urged to send similar telegrams protesting the passage of these bills.

CUMBERLAND COUNTY

Frank J. T. Aitken, M.D., Reporter

The April meeting of the *Cumberland County Medical Society* was held on April 8, 1952, at Richards Farm near Vineland. The annual election of officers resulted in the following selections:

President: Dr. Norman Henry, of Vineland, Vice-President: Dr. Kurt Hansen, Millville, Treasurer: Dr. Nicholas Marchione, Vineland, Secretary: Dr. Mary Bacon, Bridgeton, Reporter: Dr. Frank J. T. Aitken, Bridgeton; Elected to Executive Board for 1 year: Dr. Carl Ware, Dr. Albert Kump, Dr. Kenneth Corson; Judicial Committee: Dr. Sherman Garrison; District Judicial Council: Dr. Albert Kump; Delegate to Medical Society of N. J.: Dr. Mary Bacon; Alternate Delegate: Dr. O. J. Desan-

TIS; Nominating Committee Delegate: DR. CARL WARE; Alternate Nominating Committee Delegate: DR. MARY BACON.

Under new business, an announcement was made of the formation of a Woman's Auxiliary. An advisory board consisting of Dr. Carl Ware, Chairman, Dr. Kurt Hansen and Dr. Kenneth Corson was appointed.

After a highly successful year in office, President E. C. GREENE presented the gavel to Dr. Henry, who conducted the remainder of the meeting.

The speaker of the day was the distinguished and genial DR. JAMES SHIPMAN of Camden who discussed the treatment of "Traumatic Emergencies of the Eye", dwelling upon the important considerations in examinations and in the treatment of foreign bodies, abrasions, penetrating injuries, drug sensitivities, minor surgery, tear duct occlusions, conjunctival repairs, palpebral repairs, canthus repairs, the use of compresses, choice of antiseptics and anesthetics. His talk was very well received.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

Gloucester County Medical Society held its February meeting the evening of the 21st at the Woodbury Country Club, ANTHONY J. DIMARINO, M.D., presiding.

Following the reading of the minutes, the scientific portion of the meeting was devoted to "Do's and Don't's of Office Urology" the speaker being FRANCIS G. HARRISON, M.D., urologist at the Presbyterian and Graduate Hospitals, Philadelphia, Pa. This was a most practical and interesting presentation, and many points were learned by the listeners.

A letter was read stating that the home in Vineland for Disabled Soldiers, Sailors, and their Wives needed more medical personnel. Anyone interested should contact the secretary, Dr. Clarence Bowersox.

Joseph F. Hughes, M.D., requested permission to write a letter to the Red Cross permitting nurses under his supervision in time of disaster to administer certain drugs. Dr. Hughes was advised to present his detailed letter at the next meeting for approval.

I. N. Patterson, M.D., suggested that a letter be written to the district Health Office complaining that there was no one available on weekends.

ANTHONY J. DIMARINO, M.D., presided at the regular monthly meeting of the *Gloucester County Medical Society* at the Woodbury Country Club, March 20, 1952.

FRED G. MEDINGER, M.D., director of the Tumor Clinic at the Abington Memorial Hospital, Abington, Pa., with the aid of slides very graphically presented the subject "Cancer and Allied Diseases of the Breast".

A letter concerning fee-splitting was presented from the Mercer County Medical Society. Gloucester County went on record as approving the sentiments of Mercer County and our secretary was instructed to write them a note to that effect. Joseph F. Hughes, M.D., moved that A. J. Battaglia, M.D., formerly of Woodbury and now taking a residency in Atlantic City, be exempted from paying yearly dues. This motion was passed and the secretary was requested to so notify Dr. Battaglia as well as the State Medical Society and the American Medical Association.

Dr. DiMarino stated that the Division of Employment Security wishes to secure consultants for examination of protracted cases of disability. Anyone interested in this type of work should contact Dr. DiMarino.

A letter was read and filed from the American Red Cross stating that Immune Globulin was available free of charge at the Underwood Hospital. This substance was for the use of indigent or private patients.

James G. Kehler, M.D., was selected to attend the conference concerning the proposed medical school in New Jersey.

Dr. Joseph Hughes read the letter he had prepared for the Disaster Committee concerning the administration of drugs by nurses in various aid stations. This letter was approved and forwarded to the Red Cross.

HUDSON COUNTY

John L. Varriano, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting at Murdoch Hall, Jersey City Medical Center, on March 4, 1952, with its president, DR. WILLIAM J. GLEESON, presiding.

Dr. Gleeson reported that a new plan for meeting the emergency and night calls problem in Hudson County is under consideration and requested that members desiring to contribute suggestions contact any member of the recently appointed special committee—Drs. Bahnson, Campana, DeFusco, Driscoll, Myerson and Quaglieri.

For the scientific session, DR. ROBERT D. DRIPPS, associate professor of Anesthesiology, University of Pennsylvania School of Medicine, was the guest speaker. Dr. Dripps' subject was "Current Concepts of Shock and Its Treatment, Including Experience with Blood Expanders".

With DR. WILLIAM J. GLEESON presiding, *Hudson County Medical Society* held its regular monthly meeting at Murdoch Hall, Jersey City Medical Center, on April 1, 1952.

The Committee for Postgraduate Medical Education submitted a summary of the recent postgraduate course in "The Diagnosis and Treatment of Liver Disease" through its chairman, Dr. Ginsberg; while the Committee on Group Insurance, through its chairman, Dr. Trewhella, reported on the approaching campaign for enrollment of Hudson County Medical Society members, as a group, in the Hospital Service Plan of New Jersey.

Elected to membership were DR. JACK E. MARCUS of Bayonne, and DR. MICHAEL H. BERMAN of Jersey City. Reinstated as members were DR. IRVING SCHWARZWALD of West New York, and DR. FERDINAND J. PFLUG of Hoboken.

Members nominated from the floor to serve as the Nominating Committee in 1953 were: Dr. John A. Botti, Dr. John J. Quinn, Dr. Morris J. Weiss, Dr. Eugene M. Kiely, and Dr. J. Lawrence Evans.

Guest Speaker was Dr. Henry Dolger, adjunct physician in Metabolic Diseases, and chief of Diabetes Clinic at Mt. Sinai Hospital in New York City, whose subject was "The Practical Management of Diabetes".

MIDDLESEX COUNTY

George M. Benko, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was brought to order by Dr. Charles H. Calvin, the president, at 9:00 p. m. on March 19, 1952, at the Roosevelt Hospital, Metuchen.

Dr. Seymour Lifschutz of New Brunswick was elected to Regular membership from Associate. Drs. John Henderson, New Brunswick and Steven O. Fortay, Woodbridge, were elected to Regular membership on transfers from the New York and Passaic County Medical Societies respectively.

Dr. William Kuhn, chairman of the Advisory Committee to Medical-Surgical Plan of New Jersey, reported that this Plan was losing favor with many major industries of the state due to its lack of provisions for persons with an income of $5000 or more. He stated that those considering the problem suggested that the $5000 and above income group be included in the Plan by an increase of premium of 1½ per cent. Also considered was a provision for reimbursing the attending physician who worked up a case before a surgeon was called in. This last issue was variously received in different localities of the state—with some calling it fee-splitting and others being in high favor of it.

Dr. Kuhn was reappointed to head a committee of Drs. George Henderson, Philip Mangogna and Benjamin Copleman to further study and report upon this issue.

In accordance with the recent request from the Physicians Placement Bureau, Drs. Stanley Gadek, F. S. Taber, C. W. Hoffman, L. S. Downs, Martha F. Leonard and Edward J. Novak were appointed to the Physicians Placement Service Committee.

Dr. Sidney Becker then asked Mr. H. T. Tesch to begin the forum on the subject: "Medicine Treats the Alcoholic". Mr. Tesch pointed out that after a pilot study, efforts were being made by the state to have alcoholics treated on a local level at general hospitals. He was gratified at the realization that organized medicine and the public were becoming sufficiently cognizant of the problem.

Dr. Thomas A. McGuire, the next speaker, pointed out that the disease had a high incidence among professional and other skilled groups and that it behooved the general practitioner to become sufficiently trained in its treatment. Dr. C. Nelson Davis, the final speaker, indicated that the disease was closely associated with many other problems of the world, both medical and social. He felt that, whereas it was not possible to save any of those afflicted with this disease as recently as 10 years ago, it is now possible, with modern methods and drugs, to save one out of three.

The regular monthly meeting of the *Middlesex County Medical Society* was held on April 16, 1952, at 9:00 p. m., at the Roosevelt Hospital, Metuchen. Immediately after Dr. Charles Calvin brought the meeting to order, he introduced Dr. F. J. Lovelock, the speaker of the evening, who spoke on "The Role of the General Practitioner in the Overall Management of Minimal Tuberculosis".

No business was transacted because a constituted quorum did not attend the meeting.

MONMOUTH COUNTY

Sidney M. Hodas, M.D., Reporter

A regular meeting of the *Monmouth County Medical Society* was held on February 27, 1952, at the Monmouth Memorial Hospital, Long Branch, with President J. Berkeley Gordon, M.D., presiding.

The guest speaker, Dr. Sidney P. Schwartz, associate clinical professor of Medicine, Columbia University College of Physicians and Surgeons; cardiologist, Montefiore Hospital, New York, gave an extremely comprehensive presentation on "Rheumatic Fever".

The following officers for the coming year were elected: *President,* Dr. Anthony J. De Vita; *President-Elect,* Dr. George J. McDonnel; *Secretary-Treasurer,* Dr. Howard C. Pieper; *Assistant Secretary-Treasurer,* Dr. John C. Clark; *Reporter,* Dr. Sidney M. Hodas; *Executive Committee,* Dr. John W. Hardy, Dr. William F. Jamison, Dr. Armand F. Verga; *Judicial Committee,* Dr. Cornelius C. Perrine; *Representative to District Judicial Council,* Dr. John W. Hardy.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Medical Society Building on March 18, 1952. Dr. Sandor A. Levinsohn, the President, presided at the meeting.

At the business session held prior to the scientific meeting, the Society voted to approve the fund-raising campaign of the Passaic County Chapter of the American Cancer Society.

Mr. Henry Pohl and Mr. Murray L. Cole, gave a demonstration of the Holger Nielson method of artificial respiration, under sponsorship of the American National Red Cross.

Wilburt C. Davison, M.D., professor of Pediatrics, Duke University School of Medicine and Attending Pediatrician, Duke Hospital spoke on "Fallacies and Fads in Infant Feeding", which was illustrated by lantern slides.

The regular monthly meeting of the *Passaic County Medical Society* was held at the Medical Society Building on April 15, 1952, at 9:00 p. m. Dr. Joseph M. Keating, Vice-President, presided in the absence of the President, Dr. Sandor A. Levinsohn.

At the business session preceding the speaker of the evening, the following were elected to Associate membership: Sidney Cohn, M.D., Passaic, and Nicholas B. Salisteam, M.D., Passaic.

Dr. Keating announced the plan to establish eight sections in the specialties and general practice, and a Postgraduate Program, under the Chair-

manship of Dr. Wayne W. Hall. This program is in keeping with the purpose of making maximum use of the Society building.

A resolution on the death of DAVID POLOWE, M.D., was read and adopted.

Dr. Irving Selikoff, Chairman of the Program for the evening, introduced the speaker of the scientific session, ARTHUR M. FISHBERG, M.D., clinical professor of Medicine, New York University-Bellevue Medical Center Postgraduate Medical School; Diplomate American Board of Internal Medicine; director of Medicine, Beth Israel Hospital, New York City. Dr. Fishberg's subject, "Hypertension and Nephritis" was illustrated with lantern slides. His lecture was very well presented and exceptionally interesting and educational.

Following the program for the evening, a petition addressed to Governor Driscoll requesting that he veto the Chiropractic Bill (S139) was signed by the members present.

SALEM COUNTY

Joseph H. Fishbein, M.D., Reporter

On April 18, 1952, at the DuPont Country Club, the *Salem County Medical Society* heard a most enlightening talk by DR. ANTHONY DEPALMA, Jefferson Medical College, on "Hip Deformities in Children". Early recognition before irreparable damage had occurred was stressed and a list of early signs to look for was clearly outlined.

The business meeting was conducted by DR. R. LOUIS SILVERMAN and a variety of subjects was discussed. The Society unanimously passed a resolution condemning the action of the Board of Managers of the Salem County Memorial Hospital in barring all but Board certified surgeons in the performance of all surgical procedures.

A letter from the Mercer County Medical Society condemning the proposal of the Medical-Surgical Plan of New Jersey to provide fees for assistants was read. The Society was not in sympathy with the views of the communication and a resolution was unanimously passed favoring the projected plan provided it meets with the approval of the Ethics Committee of the Americal Medical Association.

A letter was read from Dr. Harry F. Suter requesting the membership not to re-elect him as Secretary-Treasurer as his plans for the coming year will take him out of town for a considerable portion of his time. Dr. Suter has served in this capacity since 1943 and the Society has become dependent on his leadership and management.

With the membership acting as a nominating committee, the following officers were elected for the coming year: President—DR. JOHN STANGER MADARA; Vice-President—DR. HARRY W. FULLERTON; Reporter—DR. JOSEPH H. FISHBEIN; Delegate— DR. R. LOUIS SILVERMAN; Secretary-Treasurer — DR. FORD SPANGLER.

Plans were projected for the annual Shad Dinner with provisions to invite members of the local press and the speakers from the previous year.

SOMERSET COUNTY

C. E. Case, Jr., M.D., Reporter

The regular monthly meeting of the *Somerset County Medical Society* was held on March 13, 1952, at the Somerset Hospital Nurses' Home, DR. IRVING KLOMPUS presiding.

S. H. CARSLEY, M.D., of Cranford, N. J., presented a lecture on "Common Problems in Allergy". Dr. Carsley reviewed the current therapeutic approach, and the success of his talk was attested to by the lively interest demonstrated.

UNION COUNTY

Leslie M. Townsend, M.D., Reporter

A regular meeting of the *Union County Medical Society* was held at the Johnson and Johnson Auditorium in Cranford on March 12, 1952, with DR. LOUIS S. WEGRYN presiding. The program included a panel presentation by some of our own members on *Interpretation of the Judicial Code and Judicial Problems to Date. The Relationship between Doctor and Patient, and Doctor and Doctor as Reviewed by the Judicial Committee.* The chairman of this panel was DR. GRAHAM C. NEWBURY of Summit, who gave a summary of the experiences of his committee in dealing with grievance problems that had been brought before the committee. He emphasized the moral obligation of a physician to see that his practice is covered by a substitute whenever he is out of town or unable to respond to the patient's call. DR. HERSCHEL S. MURPHY provided the background information for understanding the function of judicial committees through county, district, and state levels and explained that the formation of such committees was now an accepted policy of organized medicine. DR. STANTON H. DAVIS and DR. WALTER F. PHELAN answered questions that arose and both men expressed the thought that it was medicine's hope that these committees would foster increased understanding between doctors and patients, and that many of the problems which come before the committee could have been prevented if the physician had spent a little more time explaining the reasons for unusual treatment or the seemingly unusual expense of drugs or services.

The second portion of the program was devoted to a discussion of the advisability of increasing the present minimum income level above $5000 for holders of contracts of the Medical-Surgical Plan of New Jersey. The point of view and recommendations of the administrators of this plan for the Medical-Surgical Plan were ably presented by MR. H. THEODORE SORG and MR. JAMES E. BRYAN. After much discussion it was finally voted and passed that the Union County Medical Society would go on record as approving in principle the increased net income provision for subscribers.

As part of the routine business of the society the following men were elected to membership: KENNETH DAY and WILLIAM T. STRAUSS of Summit; JOHN P. WARTER of Plainfield; and GENE ZAINO of Plainfield.

WOMAN'S AUXILIARY

MRS. EDWARD H. DYER, PRESIDENT 1952-53



Mrs. Edward H. Dyer, a native of Philadelphia has resided in Ventnor since early childhood. She attended school in Ventnor and Atlantic City and is a graduate of Montclair State Teachers' College. She was a kindergarten teacher in the Ventnor schools until her marriage.

Mrs. Dyer has been a member of the Atlantic County Auxiliary to the Medical Society since 1934 and served as its president in 1946-47. She has been active in the State Auxiliary since 1947, serving as chairman of various committees. During 1951 she was State Conference Chairman and President-Elect. She is active in many civic and welfare organizations.

Dr. and Mrs. Dyer were married in 1934 and have three children. Their daughter, Virginia is a student of Mt. St. Joseph Academy at Chestnut Hill, Pa., and their two sons Edward III and William attend grade school. Dr. Dyer serves on the Obstetrical Staff of the Atlantic City Hospital and is Health Officer in Ventnor. He is a Fellow of the American Academy of Obstetrics and Gynecology.

THE 1952 SPRING PUBLIC RELATIONS CONFERENCE

MRS. STUART ZEH HAWKES, Chairman, Press and Publicity

The Woman's Auxiliary to The Medical Society of New Jersey held their Spring Public Relations Conference on Wednesday, April 30, 1952, at 10:00 a. m., at the State Society Headquarters in Trenton. Following a pleasant coffee hour, Mrs. Stewart F. Alexander, Chairman of the Public Relations Committee, called the conference to order and introduced Mrs. Thomas H. McGlade, President of the Auxiliary, who welcomed the guests and pointed out the excellent results of former conferences.

Mr. Richard I. Nevin, Executive Secretary of the Medical Society, brought greetings from the Society, in Dr. Sigurd Johnsen's absence.

The conference was called for the discussion of the building of a Medical-Dental School in New Jersey. Dr. John H. Bosshart, State Commissioner of Education, spoke on "The Need is Great and Imperative". In his discussion, Dr. Bosshart made the following points: In 1951 the Commission authorized by the Legislature reported on the need of a Medical College in New Jersey; the shortage of doctors is accentuated in New Jersey, there being one doctor to every 762 patients; there is a great need for post-graduate courses for physicians; there is also a need for more approved residencies and internships; the residencies offered and filled are below the national average, and there are no opportunities offered in ten of the specialty residencies; the in-service training of physicians is inadequate; post-graduate courses are offered, but there are no

courses of less than five days' duration and only twenty-eight courses are offered of more than five days' duration; the opportunities for youth to obtain a medical education in New Jersey are receding; many state medical colleges will not accept out-of-state students, so that there is a definite trend to loss of physicians, interns and residents, and this trend shows the need of a medical college in New Jersey. In speaking on dentistry, Dr. Bosshart pointed out that only 25 per cent of the population receive complete dental care; in 1949 the ratio of dentists to population was 1-1474, about the national average, but with the increasing demand for treatment, that number is insufficient; there is a need for postgraduate dental courses. The mission of a medical school is three-fold: to train physicians, search for knowledge and cure the sick. The health and welfare of New Jersey would benefit from a school. The medical college would be a health center containing all elements concerned with public health. It would train physicians to cure and to prevent disease, train medical social workers, technicians and sanitary engineers. Although a school would be expensive, the need is great and we must raise our sights to answer the need.

The next speaker was John G. Carr, D.D.S., the Secretary of the New Jersey State Dental Society. Dr. Carr said that in undertaking to "Build a Highway to Health" New Jersey undertakes the means by which citizens can build a way to health. Oral health is important in relation to all health. Medicine and dentistry must go hand in hand and their public health needs must be served. Public health personnel in dentistry is inadequate and the health services cannot be fully developed without a school. Men interested in public health and the advancement of science demand a school. The people contribute to funds concerned with good health and are urged to seek health benefits and treatments. The physicians and dentists should be able to meet the demands. There is a tremendous industrial growth in this state which points up the need of medical-dental growth. The industrial expansion brings prosperity and that increases the demand for health services. New Jersey has many things to boast of but the time has come to turn our energies to develop our greatest need—a Medical-Dental School.

Judge Philip R. Gebhardt, President, New Jersey State Bar Association, spoke next on the subject of financing the school. He said that there is much to be gained by the professions working together. He said "New Jersey Can Afford It" or better say—New Jersey cannot afford not to afford a Medical-Dental School. He pointed out that the Hunterdon County Medical Center is a reality, started on faith by a county of 40,000 people. We need have no fear as to the establishment of a school. He brought out the point that Pennsylvania has six medical colleges and that there are only two states in the Union with no medical colleges. New Jersey is tenth in population and fourth in industry and we must put the medical school over. Judge Gebhardt pointed out that we have the lowest per capita tax and yet we have built a two hundred and fifty million dollar turnpike which benefits those outside our state more than it does us. In stating the major revenues of the state, Judge Gebhardt showed that the medical school could be built from money borrowed from the taxes received from cigarettes ($18,000,000), beverages ($18,000,000) and pari-mutuel ($12,000,000). The Judge said that he does not approve of the state being a partner to race track gambling, but that as long as it is he feels that we should use that money for a medical school. The cigarette tax was to be used for schools and some of it is being used for general purposes.

The Judge brought out that our bonded indebtedness is ninety six million and he feels that we can raise it twenty-five million. He pledged the assistance of the New Jersey State Bar Association to the Medical-Dental School.

The Medical Director of Merck and Co., Inc., J. Mallory Carlisle, M.D., spoke on the "Impact of a Medical-Dental School on Research". He said that medical research and medical practice are now handicapped in New Jersey through the lack of a medical school. A school would offer resources now unavailable and would offer advice and guidance. Medical research includes all research to extend our knowledge, the objective being to prolong life, improve health and to bring comfort. Researchers reformulate knowledge as well as discover the unknown. All scientists have joined forces in clinical investigations of disease progress and work in close harmony with physicians. The working together of specialists in different fields is most important. The clinical problem of today may form the physiological problem of tomorrow. In each branch of a university a medical school offers much, for example the facilities offered to the engineering faculty in sanitary engineering. Medical research must be understood by the public. Too often, people see only the last step in research, not the long years of observation. Protective medicine is as important as clothing and housing. A medical school would widen interest in research, public health and increase physicians' opportunities in teaching and research. The resources and men which a medi-

cal school would bring together would mean much to the state, and with a school, medical care and research reach the highest standards. It is self-evident that medical progress depends on alliance with competent research. Our state is great, why should we not rate equally high in needed research? The states looked upon as leaders in medicine and research have excellent schools. Dr. Carlisle hopes that the Highway to Health will be a top-flight Medical-Dental School on the campus with, and associated with, a top-flight university. This hope can only be achieved by physicians, dentists and researchers working toward community welfare.

John McK. Mitchell, M.D., Dean, University of Pennsylvania School of Medicine, spoke on the advantages of a school to Education, Nursing, Public and Industrial Health. He stated that the state should furnish the facilities for education. A big section in education has been neglected in the omission of a medical-dental school. There must be a big teaching hospital in a medical school, so that not only the students but all hospital personnel may be taught. All good medical schools need nursing schools with them. The relationship of a medical school to industry is educational. Doctors should realize educational obligations and should educate patients, so that the patient is well informed about his medical problem. Dean Mitchell put the question: to whom should higher education be available? He answered—to those who are fitted to make the best use of it. State schools should not restrict applicants to state students. For the less one state restricts, the less the other states restrict. The matter of the selection of students should be left to the faculty. New Jersey must remember that they have been without a medical school and other schools have accepted their applicants. There will be many who will not be accepted in New Jersey's school, for there are always more applicants than places, the national average being two and half to one. The Dean strongly feels that the nursing school should not be an afterthought, for the nursing school supports the school and the hospital, and the nursing service is better in a teaching hospital. Public health is considered many times from too narrow a view—it is a broad field and the advantages of a school to public health are tremendous. In dealing with industry we should stir up interest early in the game and point out the interests which will accrue to the workers. Smaller industries could combine and the medical school could furnish industrial medical services, which is one method by which industrial health could be improved. A medical school is the heart of the medical research program, real advances in medicine must stem from research.

The panel was so well informed and spoke so interestingly, that there were few questions asked in the period following their talks. The Provost of Rutgers University, Dr. Gross, stated that Rutgers strongly backs the medical school and has pledged itself to campaign to educate the people for the need of a school. However Rutgers is not seeking the school for itself and does not wish to become involved in the discussion of the school site.

Arriving late, Dr. Sigurd Johnsen, State Society President, greeted the group and expressed the hope that the conference would result in the reality of a Medical-Dental School.

Mrs. Stewart Alexander deserves resounding applause for a perfectly run program, which was to the minute, and filled with interesting speakers.

AUXILIARY REPORTS

Atlantic County

Mrs. Harry Goodman,
Chairman of Press and Publicity

The regular monthly meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the Traymore Hotel on March 14, 1952, with Mrs. Matthew Molitch, President, presiding.

Mrs. Samuel Diskan, chairman of Nurse Recruitment, reported that the first in a series of teas, tours and movies was presented March 10 to all high school students interested in a nursing career.

A tea honoring the Atlantic County Auxiliary will be held on May 19 at the 25th Annual Convention of the State Auxiliary.

Guest speaker of the evening was Mr. David Brone, assistant prosecutor for the county. His topic was "Juvenile Delinquents and Narcotics".

The *Woman's Auxiliary to the Atlantic County Medical Society* held its regular meeting at the Traymore Hotel, April 11, 1952. In the absence of the president, Mrs. Herbert Axilrod, First Vice-President presided.

Dr. Philip Marvel spoke briefly to the group on behalf of the American Heart Association.

Mrs. Lawrence Wilson, chairman of Nurse Scholarship, reported that two student nurses of the Atlantic City Hospital School of Nursing had been awarded scholarships.

Mrs. David B. Allman will serve as installing officer at the Auxiliary's May 9 luncheon.

Guest speaker of the evening was Mr. Morris Batzer, who spoke to the members on "Safety in the Home".

Bergen County

Mrs. Winton Johnson,
Chairman of Press and Publicity

At a regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* held on March 11, 1952, at Bergen Pines Hospital, the following officers for the coming year were elected: President—Mrs. Stewart Alexander, Park Ridge; President-Elect—Mrs. Thomas DeCecio, Cliffside; First Vice-President—Mrs. William Magee, Palisade; Second Vice-President—Mrs. Rufus Little, Paramus; Treasurer—Mrs. Philip Busicco, Englewood; Corresponding Secretary—Mrs. Donald Kissinger, Tenafly; Recording Secretary—Mrs. Joseph Basralian, Hasbrouck Heights.

The business meeting was conducted by the President, Mrs. Thomas Garrett. A resolution to amend the constitutional by-laws with specific listing of the duties of officers was presented by Mrs. Edward Sexton for consideration, and, after written notice of this resolution has been distributed, it will be presented to the group for a vote at its regular meeting on April 8.

The Civilian Defense chairman, Mrs. Edward Grueninger, reported on the preparedness program that has been outlined by the state auxiliary to help all doctors' wives to be of greater service in their communities in the event of an emergency.

One of the most important aims of the organization was accomplished with the unanimous vote to establish a three-year full scholarship for a nursing student in each of the three nursing schools in Bergen County; namely, Hackensack Hospital School of Nursing, Holy Name Hospital School of Nursing, and the Englewood Hospital School of Nursing. The scholarships will begin with the entering class of September 1952, and will be awarded to qualified applicants recommended, in each case, by the board of admissions at the nursing school where the prospective nurse has applied for registration.

Mrs. Herbert Sharlin of River Edge, Legislative chairman, gave a full report of current legislation affecting medicine and public health.

Mrs. Sharlin introduced to the group the guest speaker of the evening, Mrs. Anton Randazzo of Passaic who gave a stimulating talk on "Legislation Is Your Business".

Following Mrs. Randazzo's speech, the Auxiliary group joined the Bergen County Medical Society as their guests for a collation.

The *Woman's Auxiliary to the Bergen County Medical Society* held its installation of officers and last meeting of the current year on April 8, 1952, at the Hackensack Golf Club. Mrs. Thomas A. Garrett of Hackensack, outgoing president, expressed her sincere appreciation to her fellow officers and committee chairmen for their unselfish cooperation in making her term in office a highly successful one. She then presented the Auxiliary gavel to the new president, Mrs. Stewart Alexander of Park Ridge. Mrs. William L. Palazzo, Hospitality Chairman, had charge of the luncheon.

The Auxiliary held its Annual Dessert Bridge and Fashion Show at the Hackensack Woman's Club. This event was attended by five hundred women interested in contributing towards the philanthropic fund, which will provide a three year full scholarship for a student nurse in each of the three schools in Bergen County, Hackensack Hospital School of Nursing, Holy Name Hospital School of Nursing and the Englewood Hospital School of Nursing. The affair, in the capable hands of Mrs. Thomas DeCecio, was a tremendous success, and $1131.00 was realized.

Camden County

Mrs. Leland M. Stetser,
Chairman of Press and Publicity

The *Woman's Auxiliary to the Camden County Medical Society* held its twenty-fifth annual Public Relations meeting on Tuesday, March 25, at the Haddon Fortnightly, Haddonfield. Highlighting the program was a heart symposium at which all phases of heart disease were discussed. Dr. Walter Crist, President of the Camden County Medical Society, served as chairman. Talks were given by Dr. Vincent DelDuca, Dr. Edwin N. Murray, Dr. David L. Andrus, and Dr. Harold K. Eynon.

Luncheon was served without charge by Mrs. William J. Browning, II, and Mrs. George B. German and the hospitality committee. During the luncheon recess, an exhibit on heart disease was on display. This was obtained from the Department of Education division of the American Medical Association. Other exhibits relating to the projects furthered by the auxiliary were demonstrated.

Dr. Edwin Ristine, chairman of the Public Relations committee of the Camden County Medical Society, in the afternoon, gave a talk entitled "Public Relations Up-to-Date".

Mrs. Harold K. Eynon, Nurse Recruitment chairman, presented the Nurse Scholarship recipients to the group, and Dr. Luman H. Tenney, Director of Mental Hygiene Clinic of Trenton State Hospital, spoke on "Adolescent Problems".

Cape May County

Mrs. Paul L. Yingling, Publicity Chairman

Our Auxiliary met at the home of Mrs. Wayne Stewart, South Dennis, on March 18, 1952.

We are very proud that our president, Mrs. William Doebele has been appointed to the Southern Regional Committee of the Council for Local Health Services of New Jersey.

Mrs. Millard Cryder reported that she is continuing to show Public Health Films to various organizations throughout the county and that they have been well accepted.

Several of our members are serving regularly, in various capacities, with the Mobile Blood Bank and Red Cross.

Our Auxiliary held its annual meeting at the new Burdett Tomlin Hospital on April 17, 1952. Mr. R. W. Powell, Superintendent, conducted a tour and explained the administration of the Hospital.

The following officers were elected for the coming year: President—Mrs. Carl Records, Cape May; Vice-President—Mrs. Benjamin Giddling, Wildwood; Treasurer—Mrs. Francis Hauk, Sea Isle; and Secretary—Mrs. Paul Cameron, Somers Point.

Cumberland County

Mrs. Thomas McGlade and Mrs. Stuart Z. Hawkes

The reorganization of the *Woman's Auxiliary to the Cumberland County Medical Society* took place at a luncheon meeting held at the Cumberland Hotel, Bridgeton, on March 17, 1952. Following a delightful luncheon, gay with St. Patrick's Day decorations, Mrs. Edwin C. Greene, wife of the president of the Cumberland County Medical Society, presented Mrs. Thomas McGlade, State Auxiliary President. Mrs. McGlade spoke on the need of an Auxiliary in every county and stressed that Auxiliary work is done only with the approval of the County Medical Society. Mrs. Ralph K. Bush, State Organization chairman, presided over the meeting. Mrs. Kenneth Corson of Vineland acted as secretary. The State Nurse Recruitment chairman, Mrs. Clarence B. Whims, spoke on the state program and stressed the need and urgency of such a program at county level. Mrs. Frederick G. Wandall, Past-President of the State, discussed the Rural and Community Health Program. Following these discussions the nomination and election of officers took place. The following were elected: Mrs. Albert B. Kump, President; Mrs. Maurice N. Harris, First Vice-President; Mrs. Kurt M. Hansen, Second Vice-President; Mrs. Kenneth Corson, Corresponding Secretary; Mrs. Edwin C. Greene, Recording Secretary; and Mrs. Nicholas E. Marchione, Treasurer. Mrs. McGlade then declared the county organized under the name of the Woman's Auxiliary to the Cumberland County Medical Society. The newly organized group discussed dues and set the date of their next meeting. Twenty-two members were present and were excited over their plans. The Auxiliary Pledge was recited at the beginning of the meeting and at the conclusion Mrs. Bush, in her gracious way, congratulated the new officers and read them instructions on "How to Keep Counties Strong and How to Be a Good Member". Mrs. Edwin Greene, Mrs. Maurice Harris, Mrs. Benjamin Berkowitz and Mrs. Anthony Pino were members of the committee responsible for the effective and pleasant luncheon arrangements.

Essex County

Mrs. Louis L. Covino,
Chairman of Press and Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held their March meeting at the Hotel Suburban, East Orange. Mrs. John Torppey presided. The Auxiliary voted to give to the Essex County Medical Society a gift of an electric Addressograph machine and an automatic attachment to their Multigraph machine. The Multigraph machine was a gift from the Auxiliary in 1949.

Following the business meeting our Program Chairman, Mrs. Stuart Z. Hawkes, presented a fashion show by Jane Engel of East Orange to a large audience of members and their guests. Clothes were modelled by Auxiliary members and their children. Tea was served immediately following the show.

On April 28, 1952, our Auxiliary celebrated its 25th Anniversary with a Silver Tea at the Academy of Medicine, Newark. Mrs. John J. Torppey presided over the meeting, at which the annual election of officers was held. Mrs. Pascal Baiocchi of Newark was elected President; Mrs. Stuart Zeh Hawkes of Boonton was named President-Elect; Mrs. Jerome Kaufman of Springfield, First Vice-President; Mrs. Philip D'Ambola of Harrison, Second Vice-President; Mrs. George Parrell of Newark, Recording Secretary; Mrs. Irving Borsher of Newark, Treasurer; and Mrs. Henry DiGiacomo and Mrs. John O'Sullivan Directors.

Mrs. George Scheller, Jr., chairman of Nurse Scholarship, reported on the selection of three girls to be given the scholarship awards for this year.

Following the business meeting, Mrs. Harry McCluskey, Safety chairman, presented Mrs. Paul O'Sullivan, who gave a humorous monologue on home safety. The Program chairman, Mrs. Stuart Zeh Hawkes, presented the first President of the Auxiliary, Mrs. George Rogers, who presented pins and orchid corsages to the charter members of the Auxiliary.

Mrs. Paul Aszody of Newark generously offered the sterling silver pins and orchid corsages as her personal gift to the charter members, in honor of the occasion. All of the Past-Presidents were introduced also. A delightful tea was held in the Council Room, with Mrs. Otto Matheke, Jr., in charge of hospitality. Mrs. Thomas Santoro was Reception Chairman.

Hudson County

Mrs. Sydney Chayes, Chairman of Publicity

The *Auxiliary to the Hudson County Medical Society* held the last meeting of the season at Murdoch Hall, Jersey City, on May 5, 1952. Mr. Richard Nevin, Executive Officer of the State Medical Society, was the afternoon's guest speaker.

Mrs. Morris Bresev, the outgoing president, turned the gavel over to Mrs. Albert Lepis of Jersey City. Taking office with the new president were Mrs. Joseph Giannasio, President-Elect; Mrs. Marshall Bergen, First Vice-President; Mrs. James Murphy, Second Vice-President; Mrs. Paul Miranti, Recording Secretary; Mrs. Harry Perlberg, Treasurer; and Mrs. William Loori, Corresponding Secretary.

Monmouth County

Mrs. Donald Bowne,
Chairman of Press and Publicity

The March meeting was held on Tuesday, March 25, 1952, at Willow Brook Inn, Fair Haven. Hostess was Safety chairman, Mrs. Elias Long. The Red Bank Chief of Police, Frank Ruether, presented a talk on the many aspects of a thorough safety program. The Nominating Committee made its report, which included a full presentation of the proposed panel of officers.

Our April meeting was held at Crystalbrook Inn, Eatontown. Guests at this meeting which was held for the purpose of election of Officers were Mrs. Thomas McGlade, President of the State Auxiliary, and Mrs. Edward Dyer, President-Elect. Members present were very pleased to get a fine overall picture of Auxiliary work from a State level.

BOOK REVIEWS

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of Northern New Jersey

The Management of Fractures, Dislocations and Sprains. By John Albert Key, M.D., and H. Earle Conwell, M.D. Ed. 5. Pp. 1232. St. Louis, C. V. Mosby, 1951. ($16.00)

Since the publication of the first edition, this book has been considered an outstanding American reference work on trauma of the skeletal system and supporting structures. Drs. Key and Conwell have revised the text frequently so as to inelude improved technies and proeedures which are practical and have stood the test of time. Obsolete methods have been deleted. In this latest edition, a short section on the use of intramedullary nails in fractures of the shaft of the femur and tibia is found. The use of intramedullary nails in other long bone fractures is not mentioned. Also not mentioned is the use of artificial femoral heads in the treatment of non-union of the femoral neck, or in aseptie neerosis of the femoral head following fractures of the femoral neck or dislocation of the hip.

This elearly written book is very readable. It is comprehensive and profusely illustrated. In every procedure described, the steps are easily followed. Attention is frequently drawn to possible pitfalls and complieations.

Since I first began to devote myself to the study of trauma of the skeletal system, I have found this work a rewarding source of referenee.

Leonard Harris, M.D.

Therapeutic Studies on Psychotics. Julius I. Steinfeld, M.D. Pp. 262. Des Plaines, Illinois, 1952, Forest Press. Price not stated.

The treatment of psychoses is, in practiee, so discouraging that one is justified in using every therapeutie avenue reputably offered. Dr. Steinfeld proposes a three-pronged attack: psychological, mechanical and chemical. He favors deep psyehotherapy with establlshment of profound interpersonal relationships and considerable manipulation of the transference and eounter-transference. As to the biochemical approach, Dr. Steinfeld cites rather impressive evidence of a relationship between decreasing pH and elinical improvement and suggests that the production of a mild but consistent acidosis might have therapeutic value. Thls he supports by aetual ease reeords. Finally he reviews in detail the effectiveness of the various types of shock therapies, by themselves, or in conjunction with psychotherapy and acidosis. The author is modest in his elaims, cautious about advancing new theories and thorough in his presentation. On the whole, a thought-stimulating book presenting a point of view which, if verified by others, may turn out to be of considerable signifi-cance in the progress of psyehiatry.

Herbert Boehm, M.D.

The Specialties in General Practice. Edited by Russell L. Cecil, M.D. Pp. 818. Phila., W. B. Saunders Company, 1951. ($14.50)

Dr. Cecil states in the prefaee to this exeellent work that he is attempting to present information in the specialties for the general praetitioner with a basic approaeh. He and his editorial staff have accomplished this feat primarily by omitting the complicated "specialist" approach to the various subjeets.

Dr. Ceeil and the 14 eontributors of special artieles present reviews of: minor surgery, orthopedie surgery and fraetures, urology, proctology, gynecology and obstetries, pediatrics, ophthalmology, otolaryngology, dermatology and psychiatry. These comprehensive sections are clearly written and numerous illustrations and tables are presented.

An abundance of practieal information and suggestions in the various fields ean be found. How often does one scan a book in a speeialty and is unable to find the answer to a simple therapeutic method? In this work, however, this valuable feature is achieved and in this basic approach to the specialties lies its greatest value.

The book attempts to eover too much and consequently the information may seem sketchy. However, the purpose of the book is to approach the basie simple therapies rather than the complicated, thus eliminating the necessity for many more words and pages. This reviewer finds, e. g., the chapter on obstetries laeking in sufficient information to be of distinct value. Notwithstanding this, the book prefaces a new approach to the writing of medical information and, as such, has very well achieved a useful purpose.

Irving L. Sperling, M.D.

Internal Medicine: Its Theory and Practice. Originally edited by John Musser, M.D. Fifth edition now edited by Michael G. Wohl, M.D. Pp. 1563. Philadelphia, Lea and Febiger, 1951. ($15.00)

Compared with the famous fourth edition, this is almost a completely new book. The number of contributors has been doubled; the material has been brought up to date and expanded; and the book itself is written in clearer type on larger size paper in double columns.

A casual perusal of the list of contributors reveals several refreshing new names of younger men who have made contributions in their special fields. The material is arranged in seven sections. In addition to the traditional groupings of diseases there have been added special sections on genetics, geriatrics, rehabilitation and psychosomatic medicine. These newer contributions in previously neglected aspects of medicine present a more comprehensive picture of the "patient as a whole".

The other sections of the book have either been completely rewritten or have been revised with the view of bringing the subject matter up to date and more comprehensible. These sections in their uniform physical make-up reveal the guiding hand of the editor. I was particularly impressed with the discussions of endocrinology and the "Collagen Diseases". The survey of Diseases of the Heart is authoritative and up to date.

The fifth edition of "Internal Medicine", as edited by Michael Wohl, is a decided improvement over the fourth edition. This revision places the reference work "Internal Medicine" among the best in its field.

Albert M. Silver, M.D.

Current Therapy—1952. Edited by Howard F. Conn, M.D. Pp. 849. Philadelphia, W. B. Saunders Company, 1952. ($11.00)

Current Therapy 1952 continues to give short, concise and to-the-point data and recommendations for therapy, following the example of its predecessors in previous years. The contributors to this volume give a national cross-section of medical thought. Although the material given is repetitious with respect to previous volumes, the varying roster of authors produces a certain freshness of approach. The text is increased in size by 150 pages. It is produced with technical excellence and close editorial attention. It answers the purpose of a single ready-to-hand essentially simple therapeutic reference guide.

Henry Green, M.D.

Illegitimate Sonnets. Merrill Moore, M.D. New York 4, N. Y., 1951. Twayne Publishers, Inc. Pp. 126. ($2.75)

Case-Record from a Sonnetorium. Merrill Moore, M.D. New York 4, N. Y. (1952) Twayne Publishers, Inc. Cartoons by Edward Stjohn Gorey. ($1.50)

Illegitimate Sonnets are so called be ause of their mixed parentage: some parts follow the traditional 8 and 6 line divisions of the classical Italian sonnet; others use the standard 4-4-4-2 model of English sonneteers. Dr. Moore's sonnets are also of doubtful legitimacy in the sense that some of his subject matter would be considered more truth than poetry by rigid-thinking prosodists. He is an able and clever versifier who has something to say that is well worth saying. It may be a crochet of mine, but I think that when he writes of swallows, or the soul of Chicago, or the inscrutability of America, he strains a little as if trying to be arty. But as a dramatic poet, he is superb. He has an uncanny knack of evoking an image of a person, of telling a story in fourteen well chosen lines. Maybe I do not appreciate his excursions into the philosophy of nature because of some lack of sensitiveness in my own soul. Or maybe Dr. Moore's forte is the pen-portrait of people. As a fellow-psychiatrist, I can applaud this poet's skill in revealing unconscious human strivings. In *Case-Record,* the cartoons alone are worth the modest price of admission. Altogether, books for the doctor's night-table: not for his waiting room.

Henry A. Davidson, M.D.

An Atlas of Normal Radiographic Anatomy. By Isadore Meschan, M.D. Pp. 593. Philadelphia, W. B. Saunders Company, 1951. ($15.00)

This book, in the words of the author, is an attempt to meet the needs of those teaching groups and practitioners who require a reference book illustrating or correlating the basic anatomy with the routine radiographic demonstration of the anatomic parts. It is especially intended for teachers of morbid anatomy where correlation between the dissecting table and the radiographic appearance is of great value. Also for teachers of radiology in the teaching of normal radiographic appearance of the different parts. It will be useful for teachers of clinical medicine whose basic training in radiology requires some knowledge of the normal before the abnormal can be understood. It is useful to the general practitioner who needs a guide and reference book for the routine x-ray examination. The inclusion of the radiographic positioning illustrations, together with the radiographic findings in such a position, would be of great help to a student in the early phases of his radiologic residency; to the medical student whose knowledge of anatomy is gained through contact with the dissecting table; and it would also be valuable in the teaching of radiographic technic. The book is profusely illustrated with photographs and copies of films of the normal anatomic parts. Enough illustrations are given to show the normal anatomy. This applies not only to the anatomy of the bony structures but also to the respiratory tract, the gastrointestinal tract, the urinary tract, as well as special examinations for pelvimetry and studies of the vascular structures, the brain and subarachnoid spaces. In fact, the entire body is thoroughly covered. The routine methods of demonstrating the anatomy in these areas by x-ray are adequately described and illustrated.

Frank P. Carrigan, M.D.

Diagnostic Bacteriology. By Isabelle Gilbert Schaub, A.B., and M. Kathleen Foley, M.A. Edition 4. Pp. 356. St. Louis, C. V. Mosby Company, 1952. ($4.50)

Schaub and Foley's *Diagnostic Bacteriology* is obviously not designed as an encyclopedic reference work but rather as a laboratory manual for the medical bacteriologist. Consequently, it is not overburdened with an impressive array of useless and impractical procedures. It covers the essential bacteriologic procedures and problems simply and briefly, and is a valuable text for the student technician; at the same time, it is sufficiently complete in scope for the supervising bacteriologist to use as a manual of procedures.

Harold Smolin, Ph.D.

Volume 49
Number 6

TUBERCULOSIS

ABSTRACTS

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV **June, 1952** **No. 6**

DELAYS IN THE DIAGNOSIS OF TUBERCULOSIS FROM THE INCAUTIOUS USE OF ANTIBIOTICS

By William H. Oatway, Jr., M.D., Arizona Medicine, July, 1951.

It was noted recently that case histories of newly admitted patients to a California sanatorium mentioned the use of penicillin and other drugs for supposedly non-tuberculous conditions. This often happened without any attempt to exclude or make a diagnosis of tuberculosis. It was decided to recheck such information by requestioning the patients. The results were amazing.

Forty per cent of the fifty patients in residence on February 15, 1951, had suffered to some degree from the "blind" use of chemotherapy.

A—Chemotherapy without Examination for Tuberculosis

1. A woman, age 25. "Cold" with pleurisy, treated with *sulfadiazine* and *penicillin*. Hemoptysis caused patient to insist on an X-ray. Far advanced exudative lesion found with cavity. (Delay—two months.)

2. A woman, age 26. "Bad cold" treated with *penicillin* and *aureomycin*. Diagnosis by *survey* film. Far advanced exudative lesion with cavity. (Delay—two months.)

3. A woman, age 26. "Bronchial trouble" with asthma, then "pleurisy" for one year. *Penicillin* inhalations. Diagnosis made with gastric culture. X-ray shows a subminimal lesion. (Delay—one to two years.)

4. A woman, age 29. "Virus infection" treated with *penicillin*. Diagnosis made by chance *survey* film of moderately advanced exudative disease with cavity. (Delay—two weeks.)

5. A man, age 22. "Pneumonia" with asthma, diagnosed without X-ray. Treated with *penicillin*. Diagnosed by *survey* film which showed scattered exudative patches with numerous small cavities. (Delay—possibly two years.)

6. A woman, age 69. "Virus pneumonia" diagnosed without X-ray. *Penicillin* given. Diagnosis by *survey* film later; moderately advanced lesion. (Delay—six months.)

7. A woman, age 38. "Bad cold" treated with *penicillin*. X-ray was not made until a *survey* film was taken, three months and two doctors later. Lesion moderately advanced. (Delay—six weeks.)

8. A woman, age 36. "Colds" then "pleurisy." Therapy with *chloromycetin* for one week. *Survey* film showed far advanced disease with cavity. (Delay—one to three months.)

B—Chemotherapy with the Tuberculosis Lesion Misinterpreted

1. A man, age 46. "Bad cold" treated with *penicillin* injections and inhalations. X-ray showed patchy lesions. No further study was made. *Survey* film showed slight increase in moderately advanced tuberculosis. (Delay—18 months.)

2. A woman, age 45. After accident an effusion from trauma was noted, plus a patchy lung lesion. No other diagnosis made. "Virus pneumonia" the next winter treated with *streptomycin* because of sensitivity to *penicillin*. A persistent fever forced a diagnosis of far advanced tuberculosis with atelectasis and cavity. (Delay—two years.)

3. A woman, age 54. "Lobar pneumonia." No X-ray, but "sulfa" given. Recurrent "Virus X"

bronchitis three years ago. Fluoroscopy done occasionally. *Penicillin* and *aureomycin* used. Patient continued to work as a nurse. X-rays now show far advanced disease with a large cavity and bronchogenic spreads. (Delay—three to six years.)

4. A woman, age 39. "Virus infection" treated with "sulfa," later with *penicillin*, then with *terramycin*. *Survey* film read as negative. Pleural effusion with tubercle bacilli found. Earlier films reviewed and seen to contain minimal lesion. (Delay—four to five months.)

C—Chemotherapy in Known But Forgotten cases of Tuberculosis

1. A woman, age 27. Tuberculosis known for eight years, but called inactive. "Flu." *Penicillin*, *aureomycin*, and *terramycin* were tried. A pleural effusion resulted in the diagnosis of tuberculosis activity. (Delay—one month.)

2. A man, age 36. Tuberculosis known for four years, considered to be arrested. Overwork and strain followed by "intestinal flu." Hemoptysis resulted in a diagnosis of exudative and cavitative disease. (Delay—six weeks.)

3. A man, age 44. Tuberculosis known for 10 years. A "cold" and several "sore throats." *Penicillin* therapy used, but stopped because of reactions. An active far advanced tuberculosis was diagnosed by X-ray later in the year. (Delay—six months.)

4. A woman, age 42. Tuberculosis known for 10 years. "Virus flu" treated with *aureomycin*, was followed by hemoptysis. Diagnosis of active far advanced tuberculosis. (Delay—one year.)

5. A man, age 38. Tuberculosis 14 years ago. Limited service in the Army Medical Corps. Life insurance X-rays read as negative. A "cold" with bronchitis. *Penicillin*, then *aureomycin*. X-ray showed bilateral far advanced exudative tuberculosis with new cavitation. (Delay—two to four months.)

6. A man, age 46. Tuberculosis known six years ago when a "strep throat," treated with *sulfadiazine*, relapsed and the lung disease was recognized, treated and arrested. A year ago he had bronchitis. Rest and antibiotic pills used. Moderately advanced tuberculosis finally diagnosed. (Delay—2 to 12 months.)

7. A man, age 45. Tuberculosis treated 10 years ago, and observed since by X-ray. For past year *sulfadiazine* and *penicillin* were used repeatedly for "bronchiectasis." No sputum examination. Sent to sanatorium with far advanced fibrocavernous disease. (Delay—one year.)

8. A woman, age 52. Tuberculosis was known 14 years ago and treated for four years. A "virus" infection two months ago was accompanied by fever, chills, etc. Therapy was *penicillin*, *chloromycetin* and *aureomycin*, but no X-ray was taken. She returned to work as a nurse, *in the nursery of a hospital*. An X-ray showed far advanced disease with a 10 cm. cavity. (Delay—two months.)

The 20 reported cases were fortunate enough to be diagnosed. Hundreds are in the sanatoriums and thousands in the general public right now whose tuberculous condition is being obscured by non-specific antibiotic therapy. These, and the persons to whom it could happen in the future, are the ones which greater care can protect.

Chemotherapy for lung infections may be hazardous if tuberculosis is not ruled out as a cause of the symptoms. Twenty patients in a sanatorium of 50 beds have had an appreciable delay in the diagnosis of tuberculous activity because of the use of chemotherapy and the lack of X-rays, bacterial studies, and clear thinking. The newer antibiotics give a false sense of security because of their broad field of action. The drugs are efficient and attractive, but they must be aimed more precisely at specific and vulnerable infections. The physician and patient both seem to be responsible for the delay in diagnosis. Persons who have had tuberculosis are especially at fault if they do not check on the cause of lung symptoms. A chest X-ray survey has helped some of the present patients to a diagnosis. It would be valuable to have inexpensive case-finding facilities available, and physicians would be wise to use them.

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			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	*1443*	*968*	*1380*	*17*	*8*	*38*	*1142*	*132*	*131*	*12*	*26*	*54*	*552*	*52*	*179*	*634*
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1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvatura.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

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"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

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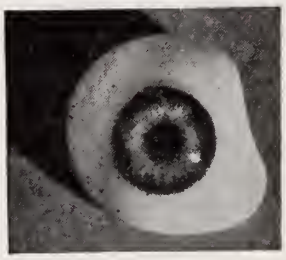
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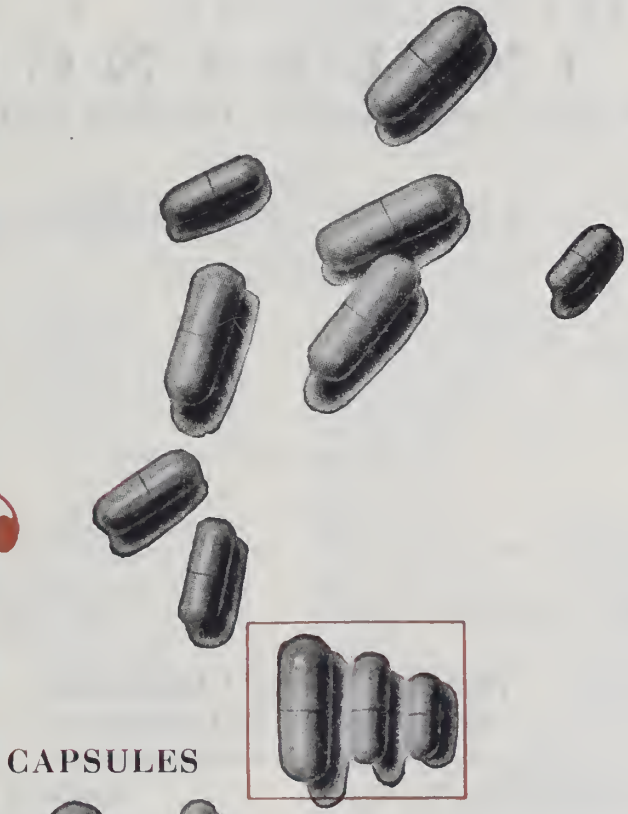
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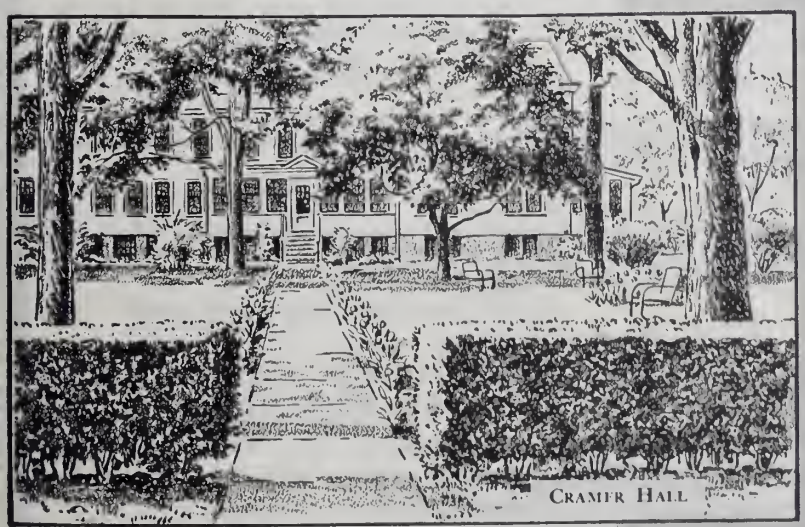
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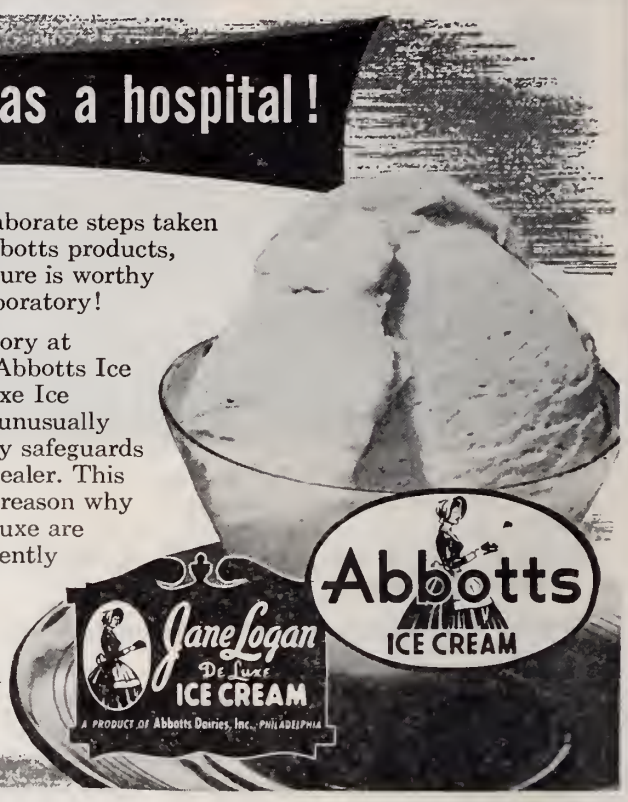
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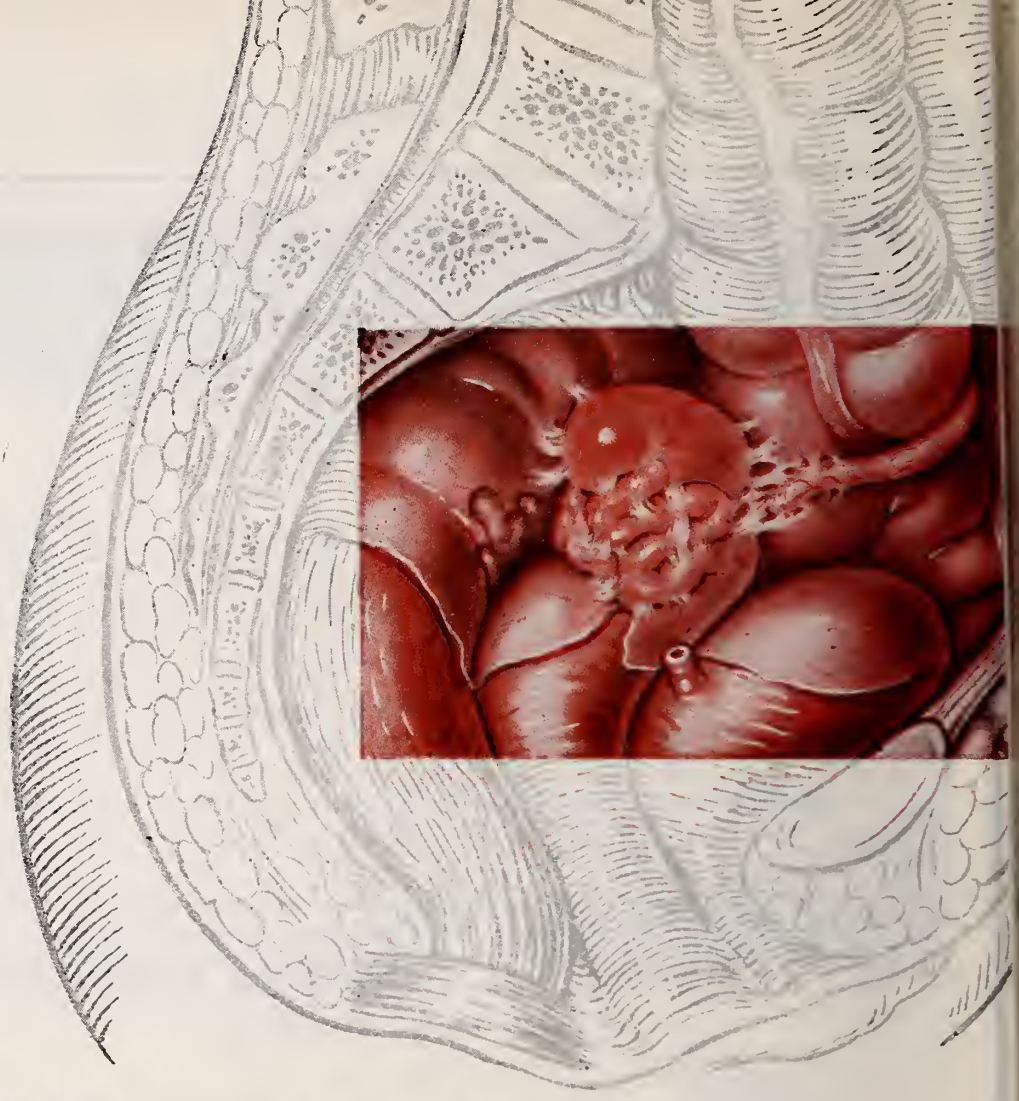
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1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:498, 1951.

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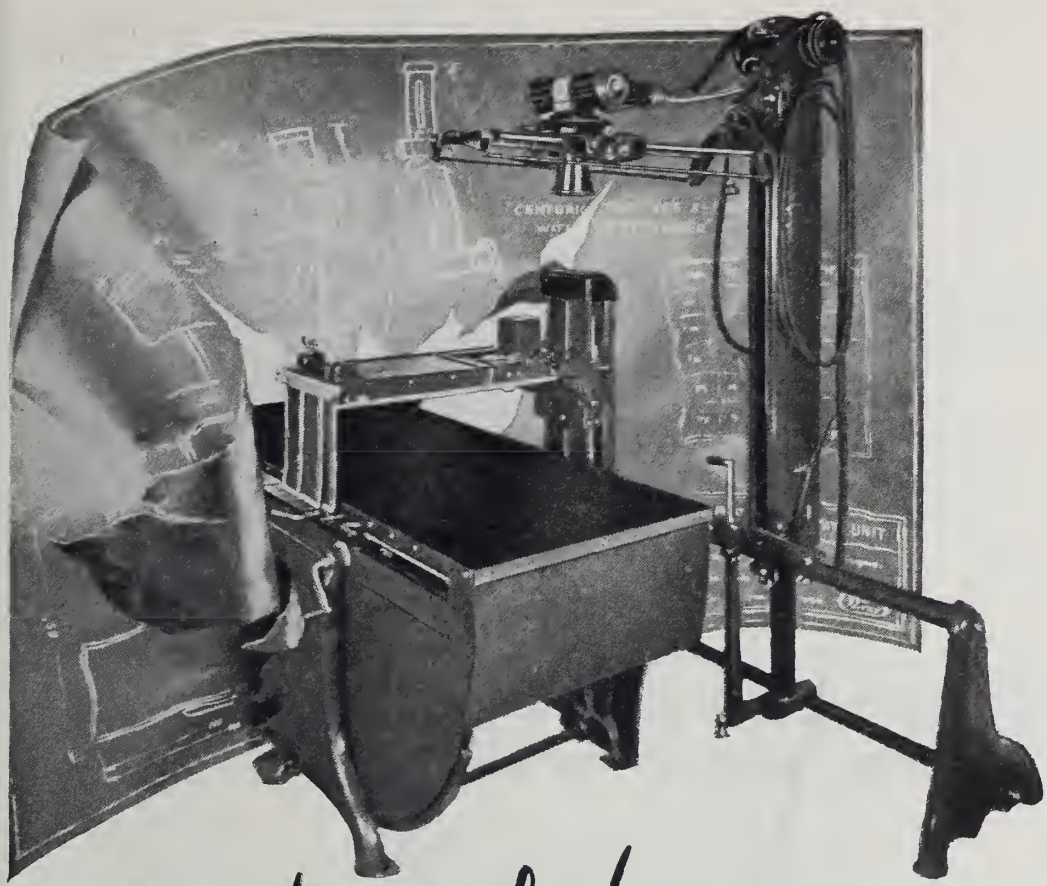
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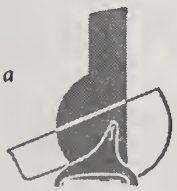


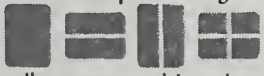
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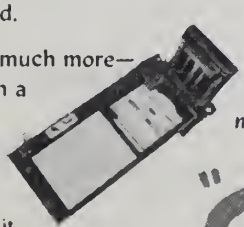
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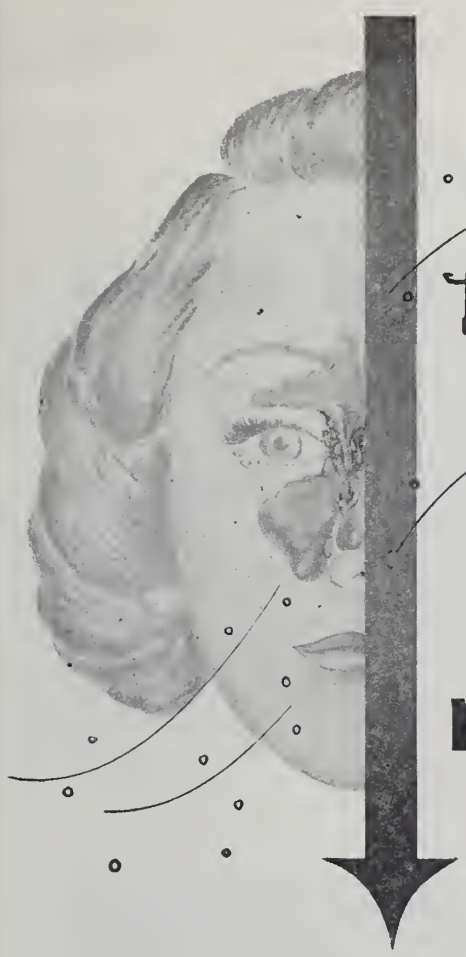
Smoother recovery after appendectomy

You can help your patients to smoother, comfortable recovery after appendectomies with Prostigmin methylsulfate. By helping restore normal peristalsis and bladder tone, the drug usually prevents intestinal distention and urinary retention. Best results are generally obtained by using Prostigmin both before and after abdominal surgery. Complete information on this and other uses of Prostigmin, based on extensive literature, will be sent upon request.

HOFFMANN-LA ROCHE INC. • NUTLEY 10 • N. J.

Prostigmin® methylsulfate

brand of neostigmine methylsulfate **'Roche'**



To open congested air passages in hay fever

NEO-SYNEPHRINE®

HYDROCHLORIDE

. . . reduces nasal engorgement . . . relieves soreness

. . . promotes aeration . . . encourages drainage

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (⅛)% solution, bottles of ½ oz.; 0.5% water soluble jelly, in ⅝ oz. tubes.

1. Van Alyea, O. E., and Dannelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine.

"therapeutic bile" overcomes stasis

what is "therapeutic bile"?

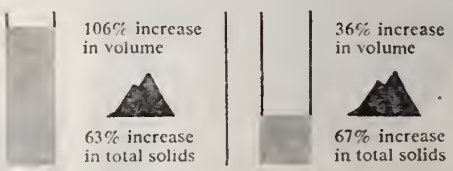
Thin, free-flowing bile in copious amounts as produced by *hydro*choleresis with *Decholin*.

what does "therapeutic bile" do?

Overcomes stasis in chronic cholecystitis and noncalculous cholangitis by flushing thickened bile, mucus plugs and debris from the biliary tract.

how does "therapeutic bile" differ from other bile?

"THERAPEUTIC BILE" is higher in fluid content and lower in solid content than bile produced by choleretics, e.g., ox bile salts.



*Hydro*choleretic: *Decholin*

Choleretic: Ox bile salts

DECHOLIN®
(brand of dehydrocholic acid)

how is "therapeutic bile" obtained?

"THERAPEUTIC BILE" is obtained by adequate dosage of *Decholin* and *Decholin Sodium*. Most patients require one or two tablets t.i.d. for four to six weeks. Prescription of 100 tablets is recommended for maximum efficacy and economy. More prompt and intensive *hydro*choleresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc. intravenously, once daily.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (brand of sodium dehydrocholate) 20% aqueous solution, ampuls of 3 cc., 5 cc. and 10 cc.

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In the reduction of simple fractures, Wydase added to a local anesthetic solution*:

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3. Reduces swelling, thus permitting snug-fitting cast

Supplied: Vials of 150 and 1500 turbidity-reducing (TR) units.

**150 TR units when added to 25 cc. of anesthetic usually suffices. See package circular.*

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MEAT... and the Cholesterol Content of the Diet

An essential constituent of human tissue, contributing to the normal functioning of all cells, cholesterol has been widely discussed as a factor in the etiology of atherosclerosis. Yet this lipid is required in many metabolic processes, and, furthermore, evidence is lacking that withholding cholesterol from the dietary is effective in preventing atherosclerosis.

In a recent plea for a return to the basic fundamentals of nutrition in the prophylaxis of atherosclerosis, it was emphasized that to eliminate cholesterol from the diet would mean to eliminate such animal foods as meat, milk, eggs, etc.* However, nutritionists are unanimous in asserting that these protective foods contain basic essential nutrients required for good nutrition and that to deny them would be "equivalent to the negation of practically all that nutrition science has taught us in the past."

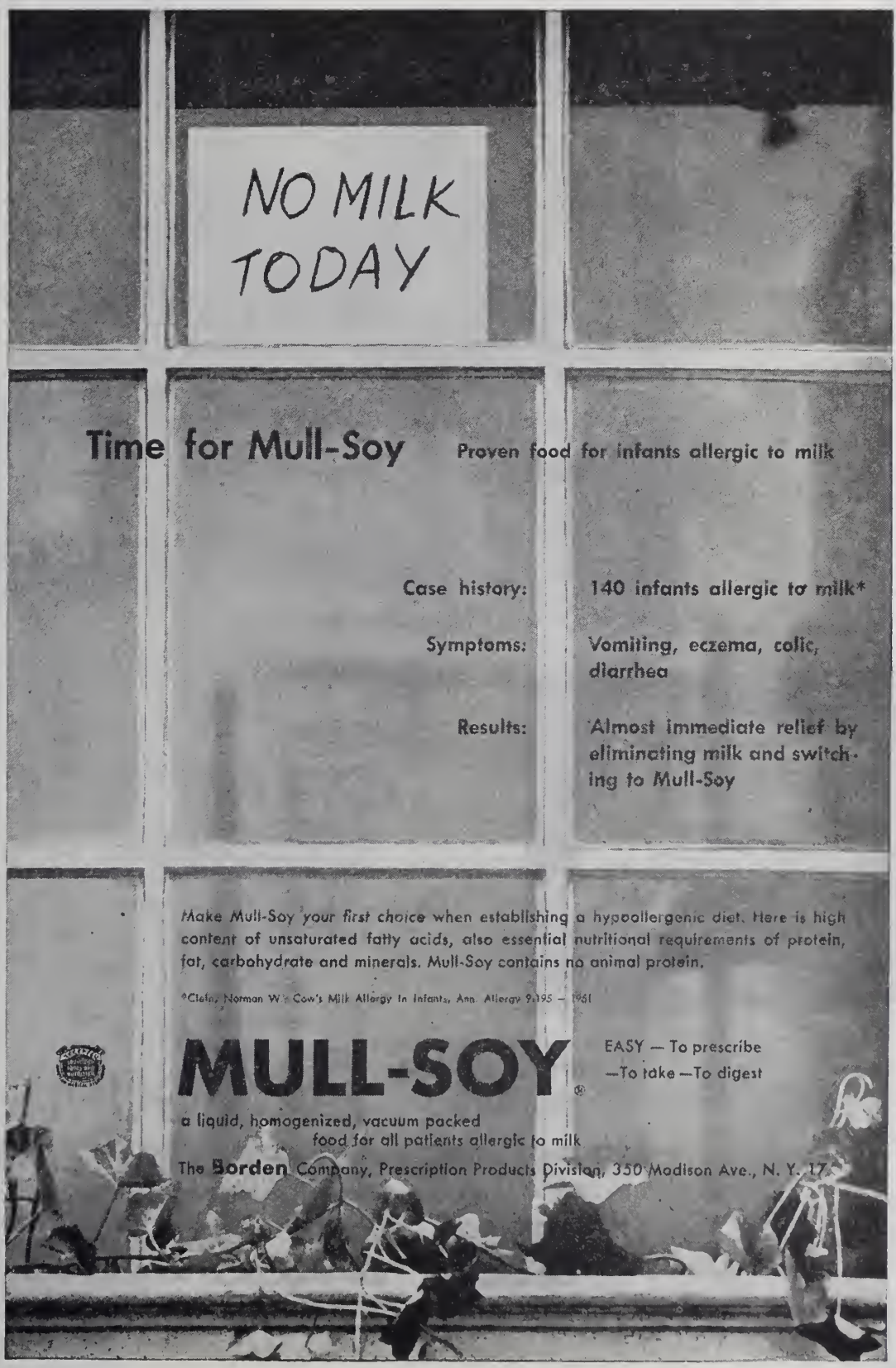
According to these authors,* elimination of animal foods from the diet to prevent the development of atherosclerosis is unjustified on the basis of present day knowledge. They state that "there certainly is no evidence that meatless, milkless, and eggless diets should be recommended as desirable to the general public."

Meat, America's favorite protein food, always has been and continues to be an important dietary source of biologically complete protein, B vitamins, and iron. Few indeed are the conditions in which its use must be interdicted.

*Hegsted, D. M.; Mann, G. V., and Stare, F. J.: Comments on Cholesterol, Editorial, Postgrad. Med. *11*:454 (May) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Main Office, Chicago... Members Throughout the United States


NO MILK TODAY
Time for Mull-Soy
Proven food for infants allergic to milk
Case history:
140 infants allergic to milk*
Symptoms:
Vomiting, eczema, colic, diarrhea
Results:
Almost immediate relief by eliminating milk and switching to Mull-Soy
Make Mull-Soy your first choice when establishing a hypoallergenic diet. Here is high content of unsaturated fatty acids, also essential nutritional requirements of protein, fat, carbohydrate and minerals. Mull-Soy contains no animal protein.
*Cleta, Norman W.: Cow's Milk Allergy In Infants, Ann. Allergy 9:195 – 1951
MULL-SOY®
EASY — To prescribe
—To take —To digest
a liquid, homogenized, vacuum packed
food for all patients allergic to milk
The Borden Company, Prescription Products Division, 350 Madison Ave., N. Y. 17

Tonsil and throat time is here again!

A-T® GUM

(contains aspirin and tyrothricin)



A-T GUM (introduced as Aspa-Tricin Gum) . . . antibiotic-analgesic . . . contains 3½ grs. of aspirin and 1 mg. of tyrothricin. A-T GUM offers outstanding advantages over topical penicillin in the prevention and treatment of mouth and throat infections.[1] Ideal for relief of local discomfort and prevention of secondary infection following oral and pharyngeal surgery . . . prevention and treatment of acute oral and pharyngeal infections.

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1 Crowe, S. J., etc. al., Penicillin & Tyrothricin in Otolaryngology Based on a Bacteriological and Clinical Study of 118 Patients, Ann. Otol., Rhinol. & Laryngol. 52:541, 1943.

safe for children and adults

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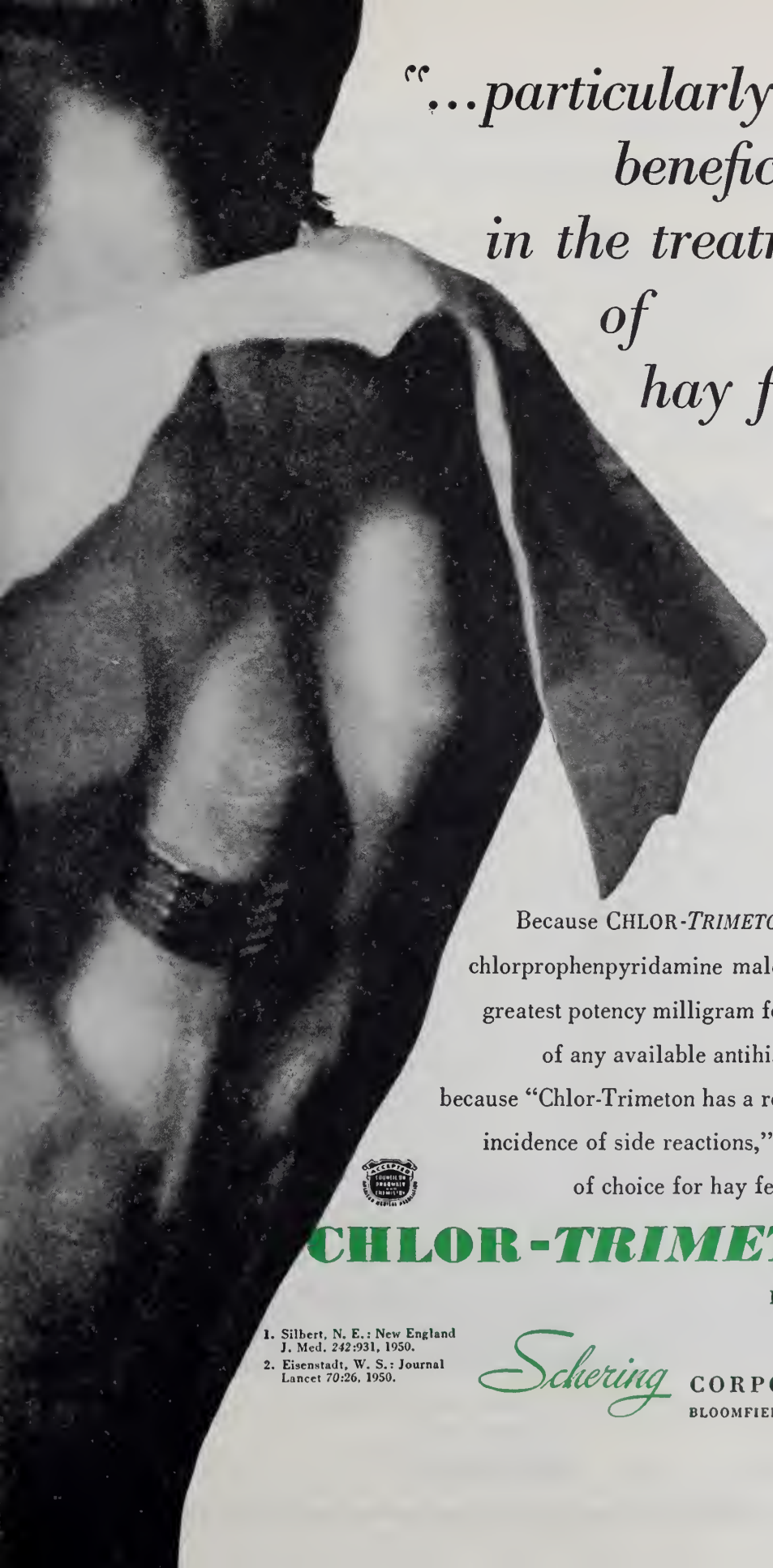
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"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26, 1950.

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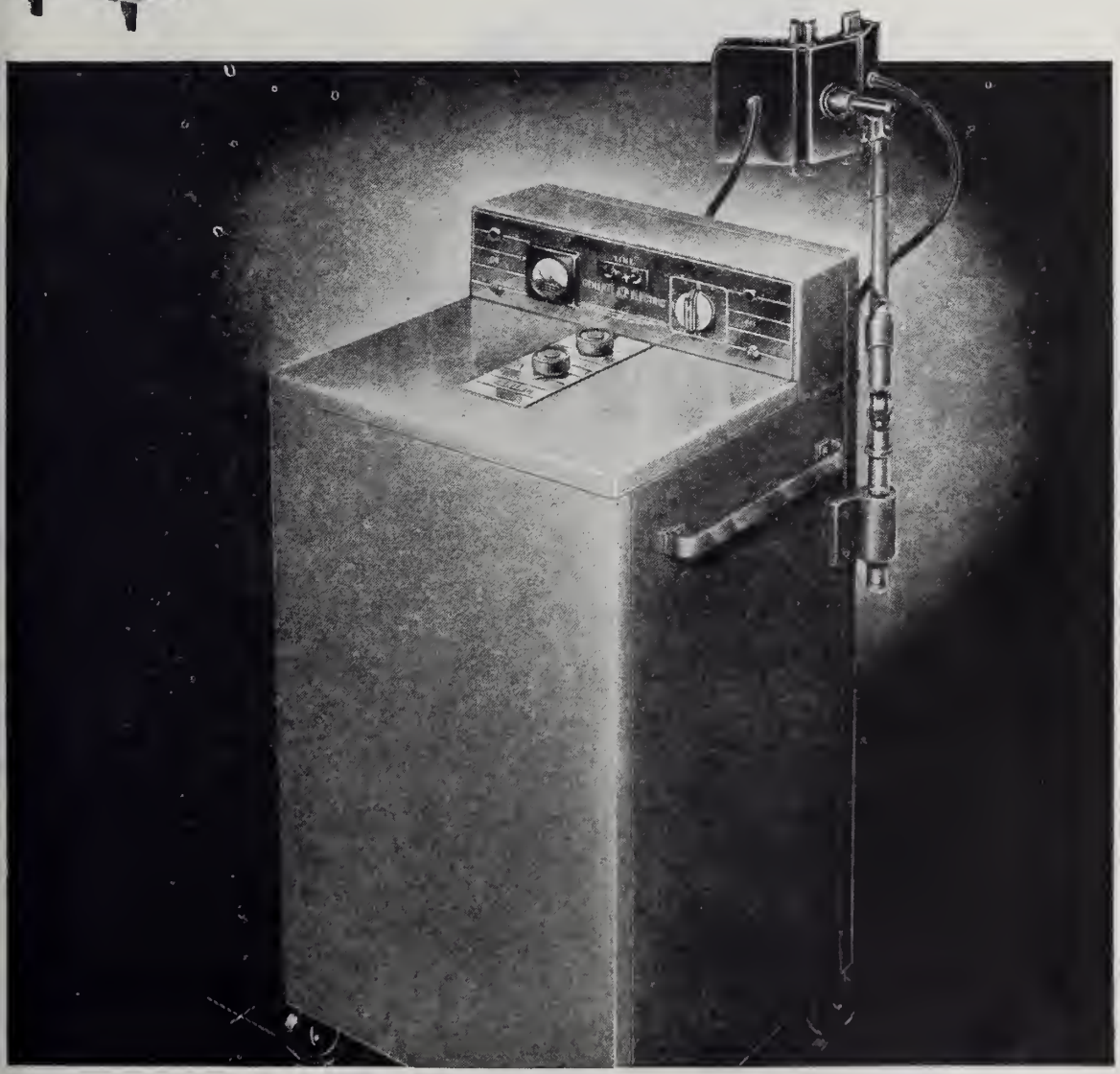
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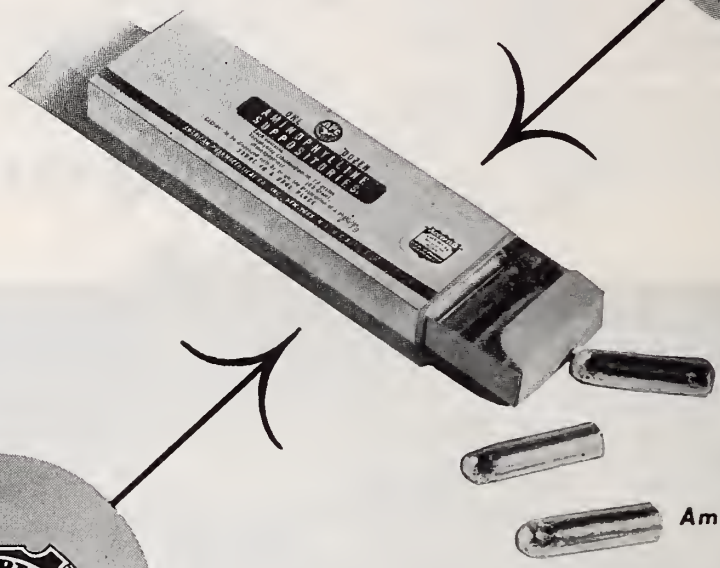
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Enteric coated tablets, 1½ and 3 gr., bottles of 100, 1000, 50

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Pass thraugh stamach withaut causing lacal irritatian ar gastric distress due ta special enteric caating. Readily disintegrate in the intestinal tract. Indicated in bronchial asthma (particularly epinephrine-fast), pulmanary ar cardiarenal edema, paroxysmal dyspnea, and Cheyne-Stakes respiratian.

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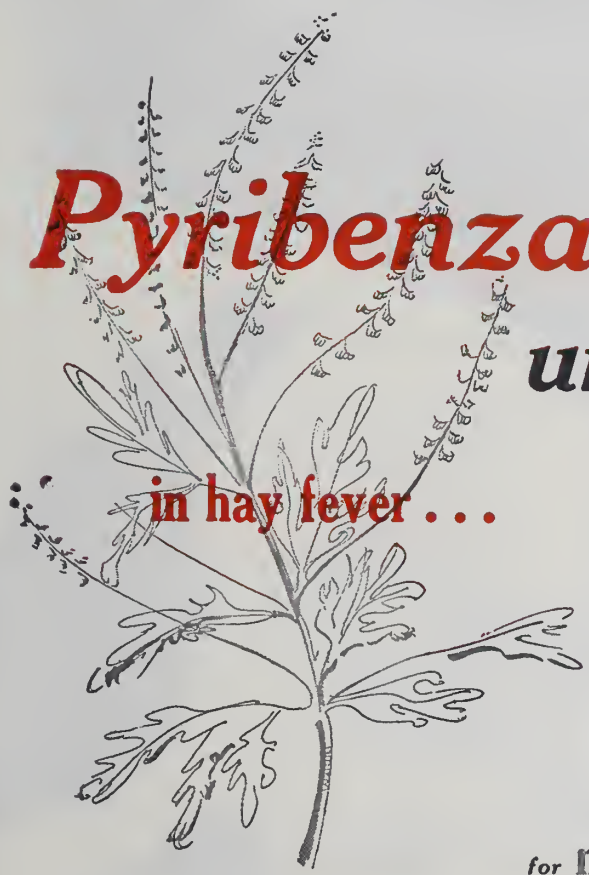
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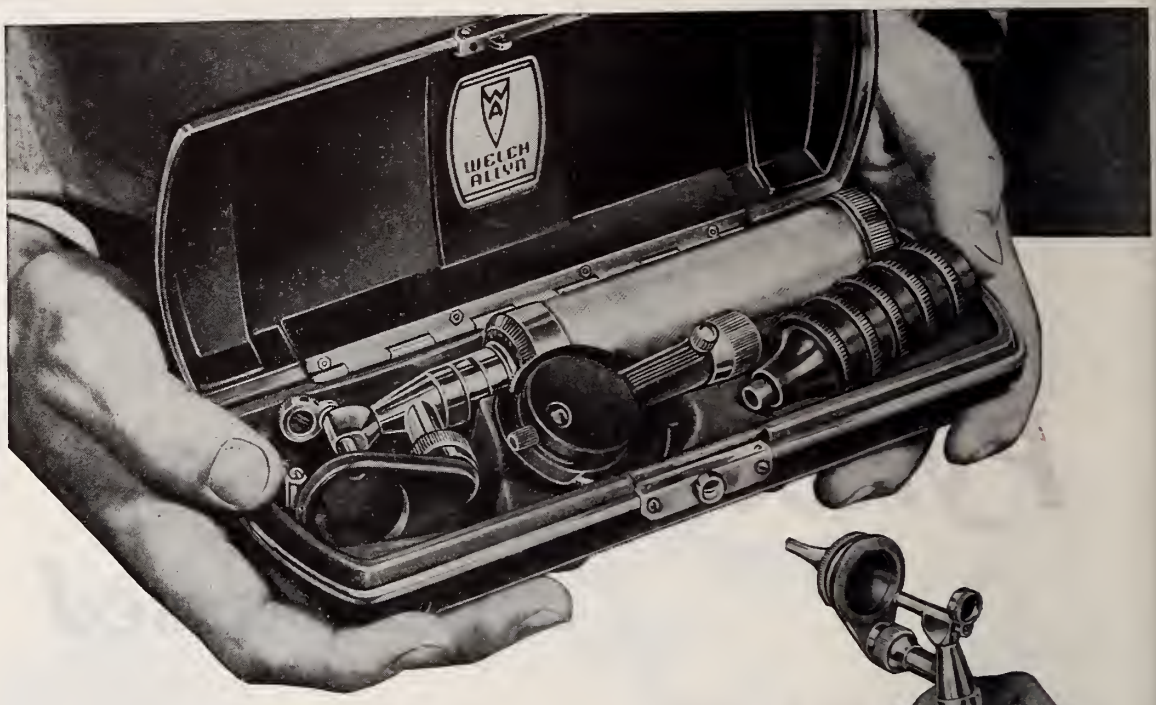
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for maximum relief

with minimal side effects

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1. *Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec.; 61:670, March.* 2. *Reich, W. J., et al. (1951), A Recent Advance in Estrogen Therapy. I. American J. Obst. & Gynec., 62-427, August.*

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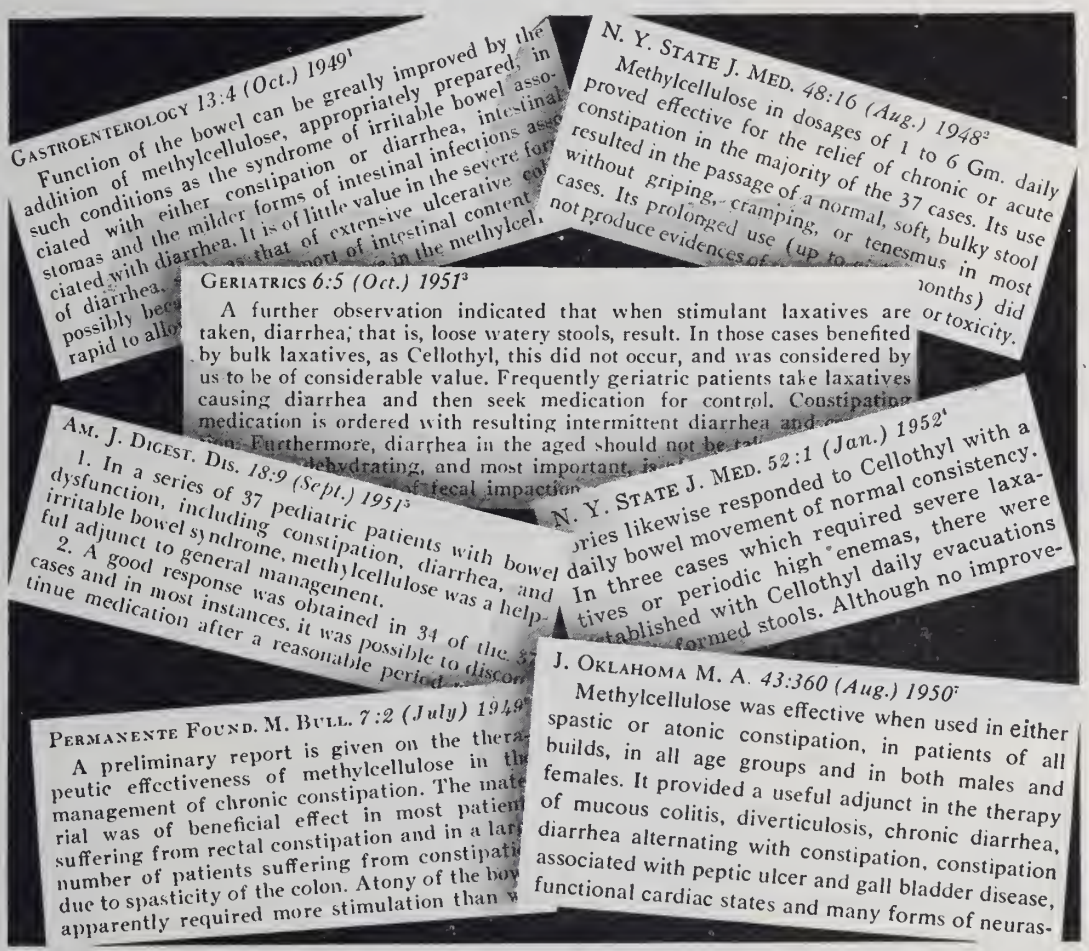
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that years of constipation can be corrected physiologically

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Cellothyl is usually prescribed three tablets t.i.d., reduced as normal function returns. Available in bottles of 100, 500 and 5,000.

Bibliography: 1. Bargen, J. A. 2. Schweig, K. 3. Wechsler, L.; Kessler, L. A., and Goldsmith, M. F. 4. Keeler, K. C., and Rusk, H. A. 5. Seidmon, E. E. P. 6. Newey, J. A., and Goetzl, F. R. 7. Musick, V. H.

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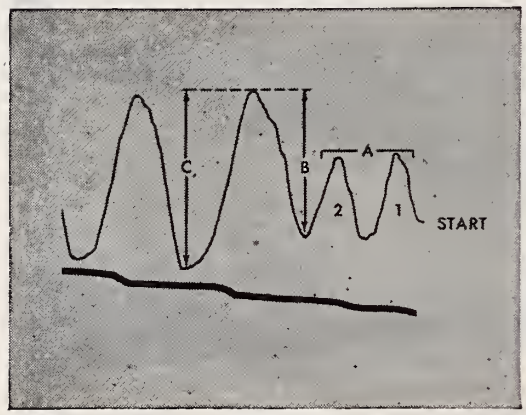
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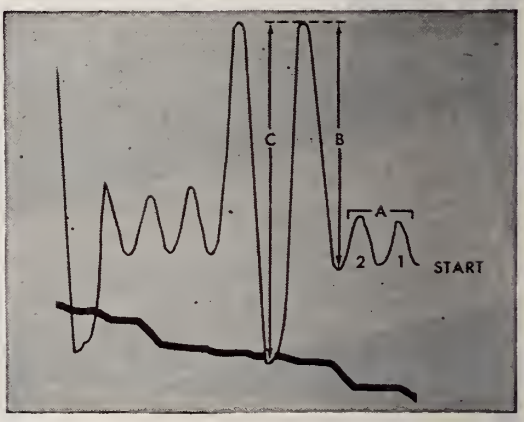
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Cortone® *provides striking benefit in intractable bronchial asthma...*





A. Tidal breathing *B. Complemental air* *C. Vital capacity*

Typical spirogram of asthmatic. Note marked diminution in vital capacity and complemental air; also, the over-all lengthening of the interval between inspiration and expiration.

This spirogram illustrates the improvement that may be expected in asthmatics following the administration of CORTONE. Note in particular the increase in vital capacity.

Increased Vital Capacity—an objective measure of the effectiveness of CORTONE

EFFECTIVE. Intended as adjunctive therapy, "orally administered, cortisone definitely relieved the symptoms of chronic intractable asthma in 26 of 31 courses given to 22 patients."

SIMPLIFIED MANAGEMENT. "The patients' weight, fluid intake and output, blood pressure, and the results of the urine examination for sugar were charted daily . . . it was found that short-term therapy could be carried out safely for up to two weeks without extensive tests if there were proper cooperation between patient and physician and careful observation. . ."

Schwartz, E., *J.A.M.A.* **147**: 1734–1737. Dec. 29, 1951.

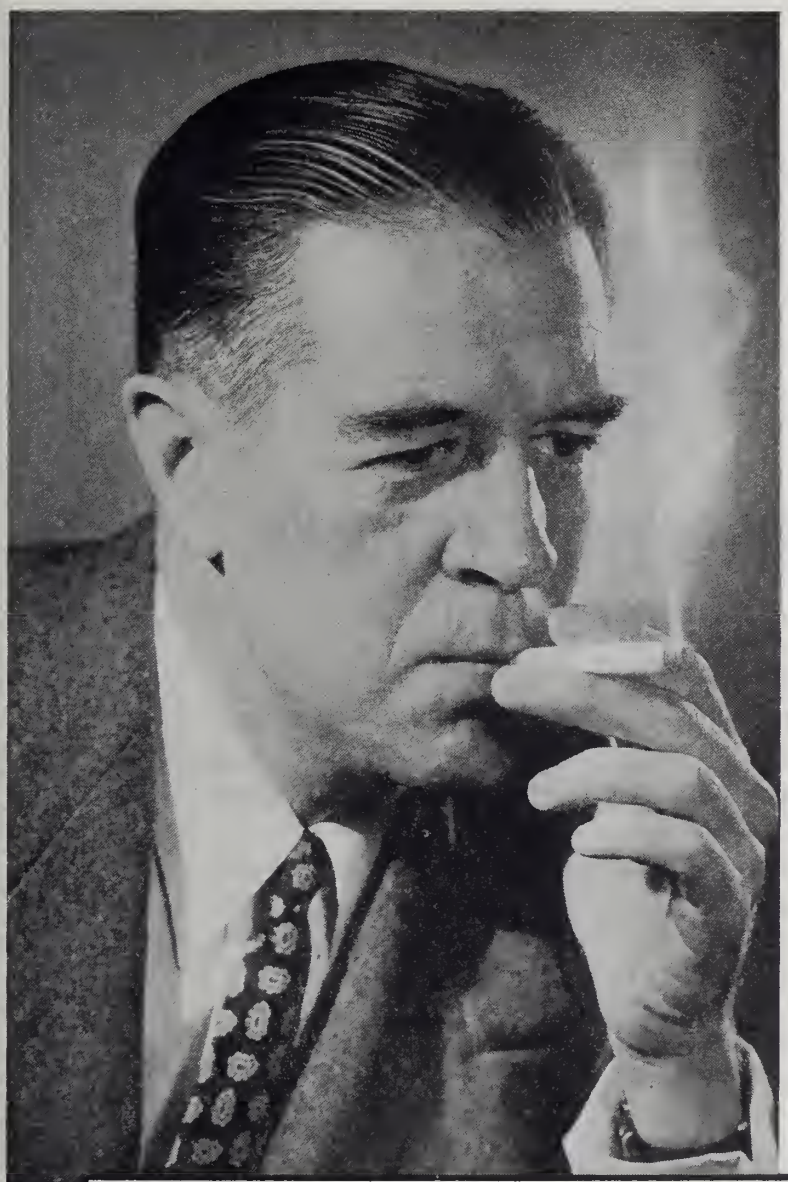
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A NATURAL Treatment for Simple Constipation

Made from Walker-Gordon Certified Whole Milk (2% butterfat), Acidophilus—a nourishing food with fresh buttermilk flavor—abounds in friendly plant-like organisms, lactobacillus acidophilus (five hundred million per ml. at time of bottling), especially adaptable to therapeutic application for constipation in children and adults. There is definite proof that an implantation of l. acidophilus bacilli in the digestive tract will crowd out and destroy harmful intestinal bacteria. Clinical studies indicate Acidophilus used successfully in 75% of cases treated.

Acidophilus In Connection With Food Allergies and Antibiotics

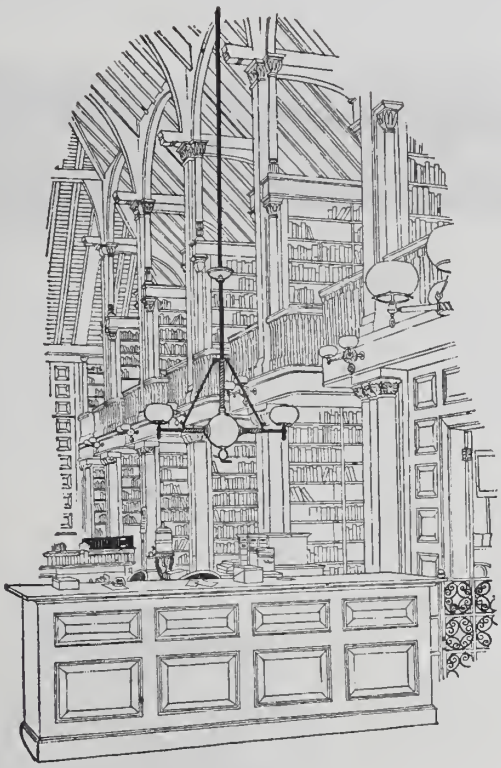
Considerable medical interest is being shown in these uses. A report on research now underway, "Acidophilus Milk and Food Allergy," also reprint, "Antibiotics Warning," will be sent to you on request.

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Hydrochloride Crystalline

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Aureomycin appears rapidly in the tissues of the ear, nose and accessory sinuses, and in the cerebrospinal fluid.

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Aureomycin has been reported to be effective against susceptible organisms in the following conditions frequently seen by otolaryngologists:

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Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

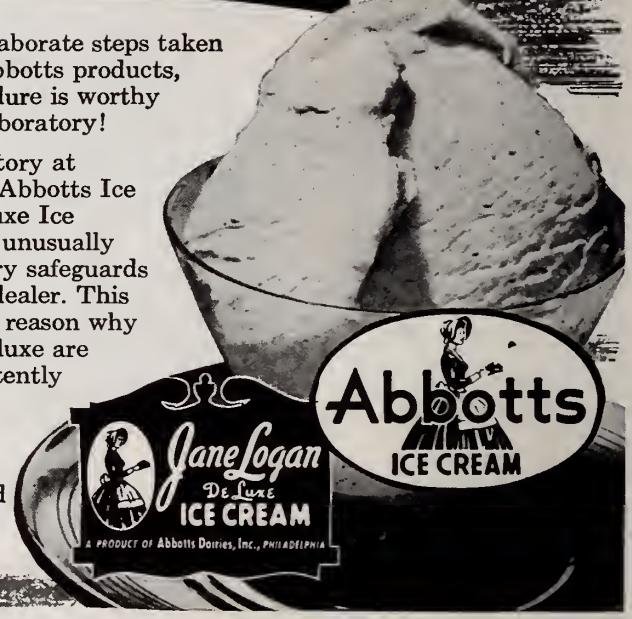
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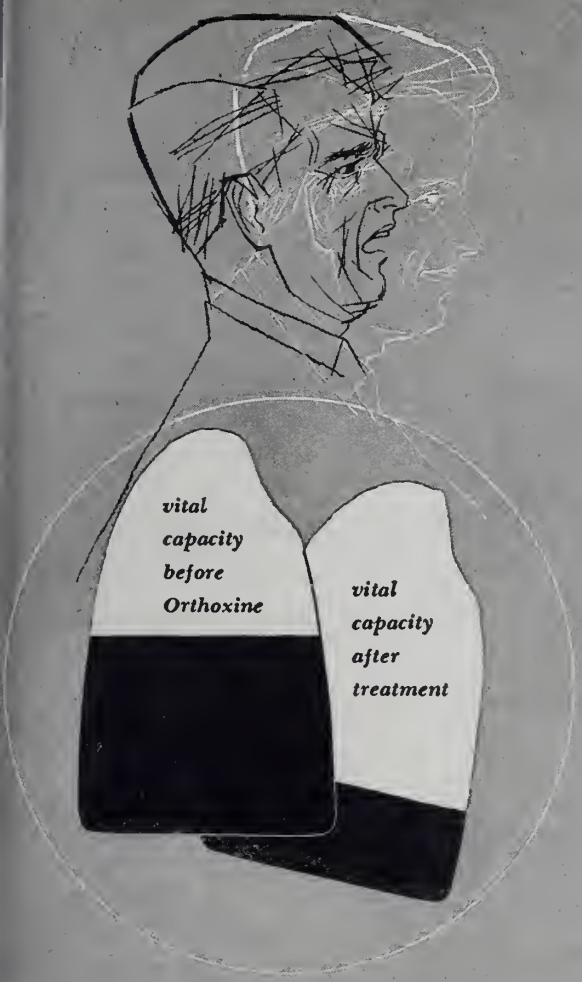
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Bottles of 100 and 500 tablets.

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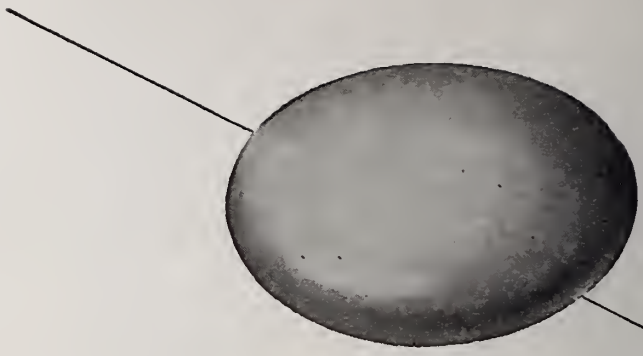
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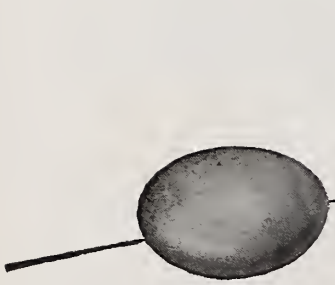
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PRESIDENT'S MESSAGE

"Good Health for Everyone" should be our slogan for the coming year. One of the most important challenges facing the medical profession today is furnishing adequate medical care to the citizens of our state.

About thirty per cent of the people of New Jersey do not have the advantages of adequate local health services. We cannot hope to have healthy citizens if poor housing facilities, overcrowding, lack of essential nutritional requirements and inadequate protective health services prevail.

Many ill-informed members of our profession think that rendering medical care to people will suffice to bring about a good health program. This is our obligation as physicians, but our interest as citizens should go far beyond this contribution. We must make every effort to stimuate our fellowmen to become conscious of their part in helping keep everyone well.

Each member of the community should play a role and become interested in a program for good health in the town in which he lives. The city officials, members of all professional and non-professional groups, labor, civic clubs, all religious, all youth and parent-teacher organizations should join with doctors, dentists, nurses and public health officers in setting up a Local Public Health Council in each town or city to plan and arrange for programs that will help to keep its citizens well and offer them opportunities for recreation and rehabilitation.

Such an opportunity is offered us in the implementation of Assembly Bill Number One. This bill has been approved by The Medical Society of New Jersey and aims at establishing fewer, larger and better health units throughout

the state. It is a permissive bill and must receive our enthusiastic support and cooperation.

Now is the opportunity for us to demonstrate in a very practical way that we are vitally concerned with the health of our citizens, that we recognize the importance of the close cooperation with all groups and agencies interested in health and that we are willing and eager to spend the time and effort in planning with them programs to bring about good health for everyone.

Harrold A. Murray, M.D.

THERAPEUTIC DERMATITIS

Dermatitis due to amateur overtreatment of a relatively insignificant primary skin disorder is becoming an increasingly serious problem for dermatologists. Many patients, on their own initiative or on the advice of well-meaning friends, relatives, or other non-professional persons, are treating themselves with potentially harmful agents, not realizing that the treatment itself is responsible for the continued cutaneous lesion. Unfortunately, even some physicians treat their patients with one medicament after another, overlooking the fact that the treatment itself is the main reason healing does not result. Advertising in the newspapers and magazines of home remedies for the skin also contributes to this problem. According to Lane,† the underlying basis for this sad state of affairs is failure to appreciate that the majority of proprietary ointments and lotions, as well as most of those offered to the physician for prescription contain chemicals which are sensitizing in nature. Prolonged treatment with such combinations of drugs, leads to an allergic dermatitis superimposed upon the underlying lesion, making the cure doubly difficult.

Lane† points out that the most common sensitizing agents are local anesthetics, sulfonamide drugs, penicillin, mercury, phenol, tar, menthol, camphor, iodine, and salicylic acid. He gives a list of unofficial preparations that contain local anesthetics, and calls attention to the fact that practically every home remedy for "athlete's foot" is a modification of Whitfield's ointment, and contains salicylic and benzoic acids, or other equally allergenic chemicals.

Results of such overtreatment dermatitides range from the unnecessary and wasteful expenditure of the public's money on ineffective and harmful drugs and the economic loss to industry resulting from prolonged disability, to the extremely serious and intractable generalized dermatitis which occurs in about ten per cent of sensitized patients. Such a generalized dermatitis is a major skin problem, requiring prolonged and expert treatment, and often involving an extended period of hospitalization.

Lane's recommendations for the prevention of therapeutic dermatitis consist primarily of common sense for the layman, who should be educated away from self-medication. For the physician, he advises cognizance of this clinical entity, which manifests itself by increased redness, itching or extension of the lesion originally under therapy. These manifestations call for immediate cessation of the noxious therapeutic agent, and the introduction of milder, blander forms of treatment. In addition, every physician is urged to acquaint himself with the chemicals comprising any preparation for the skin that he may prescribe, and to appraise himself of their allergic properties before recommending them to patients.

† Lane, C. G.: Therapeutic Dermatitis. The New England Journal of Medicine, 246:77 (January 17, 1952).

ORIGINAL ARTICLES

THE IMMEDIATE CARE OF THE INJURED THORAX *

Alfred R. Henderson, M.D., Asbury Park, N. J.

It is the purpose of this presentation to review some of the salient points in the immediate management of the injured thorax. Space will not be taken by a discussion of aftercare or of the more definitive aspects that occupy the domain of the thoracic surgeon. These injuries of the thorax are classed in three groups:

(1) Injuries of the chest wall.
(2) General principles in the management of the severely injured chest.
(3) Injuries of specific intrathoracic viscera.

INJURIES OF THE CHEST WALL

Contusions of the Chest. Serious injury to the thoracic viscera can occur with little external or symptomatic evidence. You can never be certain that contusion injury or rupture of intrathoracic structures has not occurred. Arenbery,[1] in a study of 250 cases of nonpenetrating injury of the chest, found that 11 per cent had definite post-traumatic electrocardiographic evidence of myocardial damage. Such patients must be given the same care and prolonged rest as for myocardial infarction. Chronic myocardial weakness may follow neglect of this condition.

The pain of a contused thorax may mask symptoms of underlying injury. Relief of pain in these cases is best brought about by intercostal nerve block and avoidance of tight strapping of the chest unless a progressive hematoma of the chest wall occurs. Intravenous calcium gluconate (10 per cent) often gives marked relief by its property of relaxing the spastic intercostal muscles within the segment of injury. Substernal pain, interstitial and mediastinal emphysema, cough with or without hemoptysis and dyspnea indicate rupture of the trachea or a major bronchus. Epigastric pain radiating about the lower rib cage to the back and vomiting followed by signs of shock and pleural effusion indicate rupture of the esophagus. Progressive hemothorax and shock are indications that a major vessel has been torn. These complications will be discussed under the section dealing with injuries of specific structures.

Traumatic diaphragmatic hernia is, not uncommonly, the result of blunt injury of the thorax. More often than not, however, it is not thought of and goes unrecognized for many months until vague gastric and chest disturbances bring the patient back to the physician. It is well to remember that such herniae are most often insidious in their formation and a flat chest film taken after injury will not reveal the process. The rent in the diaphragm will at first permit only a small knuckle of abdominal viscera to protrude into the thoracic cavity. As time goes on the evisceration into the chest increases with each effort and motion of the patient and finally, perhaps after many months, considerable herniation of abdominal contents may have occurred. Any case of severe chest contusion should be periodically examined at least by x-ray even when asymptomatic and certainly surveyed more thoroughly with this complication in mind if vague abdominal or thoracic symptoms should later occur.

In contusions of the chest:

1. All patients should be x-rayed.
2. An electrocardiogram should be taken.
3. Keep in mind possible visceral complications and late sequelae.

Rib fractures occur either spontaneously or result from direct injury of the thoracic cage. Spontaneous fractures are usually the result of severe coughing or from a pathologic process within the bone substance. Fractures resulting from violent coughing are usually located in the anterior or mid-axillary line where the costal attachments of the serratus anterior and external oblique muscles interdigitate and

* Presented at the monthly staff meeting of the Riverview Hospital, Red Bank, N. J., April 18, 1952.

1. Arenbery, H.: Annals of Internal Medicine, 19:326 (1943).

cause acute opposing forces to play upon the ribs.[2] In *simple fractures* of the ribs, unassociated with internal injury or other complicating factors, it is best to attempt to relieve pain by intercostal nerve block rather than by the time-honored practice of tight strapping of the chest wall. With strapping:

1. Increased displacement may occur.
2. Adhesive tape is often intolerable.
3. Pain is seldom relieved for long.
4. Restricts function of underlying lung.
5. Cough is ineffectual.
6. Dressings make x-ray follow-up difficult.

Obviously then, intercostal nerve block permits the mechanics of ventilation to continue and minimizes the possibility of complications. Recently the author has used Efocaine† as a substitute for the commonly used local anesthetic preparations, and found that one injection would usually last as long as 5 to 10 days.

Although, as a rule, strapping should not be used there are times when it is desirable to prevent freely moving spicules at the fracture site from causing further trauma to the soft tissues of the chest wall and possible intrathoracic injury. Here, strapping over a gauze pack in combination with nerve block may be useful. If multiple fractures have caused a section of the rib cage to become independently freely moveable ("flail-chest"), strapping, nerve block and lying on the injured side will stabilize the chest wall, and may be given a trial before considering surgical fixation of the rib fragments. All persons suspected of having rib injury must be x-rayed. Although the rib shows little or no displacement, it may have caused considerable trauma internally by displacement during the initial violence before the fragments recoiled back into position. X-rays can be misleading in this respect.

Complicated Fractures: When there is associated intrathoracic injury caused by the displacement of the ribs inwardly or when the fractures are extensive enough to cause a section of the thoracic cage to move paradoxically with respiration (and, therefore, cripple the respiratory mechanics) we are faced with a complicated case and one which frequently requires fixation of the fractured parts surgically. Ten to 20 per cent of persons whose traumatic lesions are associated with pleural or lung complications will die from their injuries.[3] Pneumothorax, mediastinal or subcutaneous emphysema and hemothorax or combinations of these are evidence of underlying pulmonary damage. Most often the pulmonary rent will close rapidly and unless a hemothorax is present thoracentesis will not be necessary. Blood should not be allowed to remain within the pleural space and should be removed promptly as the crippling effects of an organized hemothorax may necessitate later decortication. Lung damage will occur in about 85 per cent of cases of rib fracture. Gross, progressive hemothorax signifies intercostal bleeding or bleeding from some other large vessel and demands immediate exploration.

Direct blows to the anterior chest wall may fracture ribs on either side of the sternum. Such sternal separation results in considerable respiratory effort since the depression or sucking-in of the sternum on inspiration and blowing-out on expiration spends a great deal of force in moving the dislocated anterior chest wall. Little movement of air, therefore, occurs within the tracheobronchial tree. The patient is actually suffering from hypoxia. Simple observation and palpation of the anterior chest wall during breathing will readily reveal this situation. This demands immediate treatment since, aside from the hypoxia, the patient cannot cough out secretions which are prone to accumulate in all cases of severe chest trauma. Towel clips or sternal screws should be placed in the sternum and attached to a pulley traction system overhead or at the foot of the bed. Three to five pounds of traction weight will usually mobilize the cage sufficiently to overcome the respiratory distress. The traction system can be incorporated in a plaster bridge over the chest if transportation is necessary.

Fractures of the sternum usually occur at the manubriosternal joint with little or no displacement or motion resulting. In this situation, no active therapy is necessary. If, however, there is slipping of the fragments or displacement immediate fixation by wiring is in-

† E. Fougera and Company (New York) prepare a non-oily depot solution of a long-acting local anesthetic under the trade-name of *Efocaine*.

2. Harvey, R. M.: Am. J. Roentg. and Rad. Th., 52:11 (1947).

3. Coleman, Frank, and Custis, L.: Surg., Gyn., and Obstetrics, 90:129 (1950).

dicated. Whenever there is difficulty in reducing overlapped fragments of the sternum it is well to look for concomitant compression fracture of the thoracic vertebrae. If such a complication is found, the patient should be placed in hyperextension and another attempt be made to reduce the fragments and wire them together.

Severe blunt violence to the anterior chest may result in complete separation of the sternum from its cartilages or of the cartilages from their respective ribs. Such a separation of the sternum from the thoracic cage is referred to as "stove-in" chest. Often there is associated intrathoracic visceral damage. Maintenance of an airway free of obstructing secretions is the major difficulty here and until proper fixation can be surgically accomplished, it may be necessary to perform repeated aspirations of the tracheobronchial tree by catheter suction, bronchoscopy or tracheotomy. Towel clip traction will restore the rigidity of the thoracic cage and offer dramatic relief from asphyxia. Antibiotics should be given liberally since retained secretions in a patient whose body is immobilized by sternal traction makes him a likely candidate for atelectasis and pneumonitis.[4]

GENERAL PRINCIPLES OF MANAGEMENT

Tracheotomy: Even in the absence of significant damage of the lung or bronchial tree, an unstable and painful chest wall is capable of producing significant quantities of tracheobronchial secretions and "wet-lung". A cycle is set up whereby the pain and unstable chest wall prevent proper respiratory exchange. This in turn, favors collection of secretions necessitating an increase in respiratory effort which increases pain and improper respiratory exchange. Pain prevents effectual cough and strapping the chest will further diminish vital capacity and increase the dangers. The one step in the management of such a case which may make the difference between life and death is the performance of an *immediate tracheotomy*. It has been demonstrated,[5] both clinically and experimentally, that by performing tracheotomy in these cases the anatomical volume of the tracheobronchial tree through which air must pass to the lungs is diminished and therefore less effort is required for breathing. Less respiratory effort results in diminished thoracic cage movement and pain. Through a tracheotomy, an adequate airway can be maintained constantly and repeated aspiration can be carried out by an attending nurse. Never hesitate if you think a tracheotomy is indicated; as with cardiac arrest, you should be operating while debating the indications.

Shock: Two major types of shock are possible. Primary shock follows immediately after injury and is the result of neurogenic reflexes on the circulation brought about by pain and fear. *Secondary* shock usually appears within a few hours after injury. It most frequently results from the loss of blood volume. The clinical picture of lowered blood pressure, pallor, cold sweat and rapid shallow breathing, rapid weak pulse is known to all. Acapnia, embolism and the sudden release of toxic substances from the site of trauma into the circulation are also capable of producing this picture, and this must not be overlooked.[6]

Four important steps must be followed in treating the patient in shock with concomitant chest injury:

1. Relief of pain and anxiety.
2. Restoration of normal cardio-respiratory mechanics.
3. Restoration of blood volume and oxygen-carrying hemoglobin.
4. Chemical agents.

If *primary* shock exists (where actually very little blood loss may have occurred) the beneficial effects from transfusion are transitory and the state of shock will return rapidly following an infusion of what appeared to be adequate volume. In the *secondary* type, improvement from transfusion will be maintained provided the source of bleeding has been controlled.

1. In the relief of pain and anxiety, morphine is still the drug of choice. Because of its potential, but not common, property of depressing respiration a small dose (e.g. grain 1/6) should be given first and then repeated in

4. Samson, Paul C., and Brewer, L. A.: Journal of Thoracic Surgery, 15:162 (1946).
5. Carter, Noland, and Guseff, Jerome: Journal of Thoracic Surgery, 21:495 (1951).
6. Gray, Howard K., and Fryfogle, J. D.: U. S. Armed Forces Medical Journal, 2:1127 (1951).

one-half hour if not effective. But one other warning more important here than the possibility of depressing the respiratory center must be mentioned. In shock, there is very little peripheral circulation and repeated doses of morphine, at first ineffectual, may have a sudden cumulative effect as the blood pressure rises and the peripheral circulation improves. Be cautious with repeated doses of morphine: it is better to give small intravenous doses when possible. Intercostal nerve blocking is the best means of dealing with pain in thoracic trauma.

2. In the restoration of normal mechanisms of breathing, the maintenance of adequate airway is urgent. Unless the circulating blood can be supplied with adequate quantities of oxygen and unless intrapleural pressures are capable of returning the blood to the right heart and lungs to maintain sufficient output, there can be no revival from the shock state.

3. In considering the restoration of blood volume, several facts must be kept in mind. The physiologic state of shock is, in a sense, a protective mechanism. The fall in blood pressure, increased clotting ability, acceleration of the heart and respiratory rates, arteriolar constriction and redistribution of blood are protective phenomena to a point. The average man of 70 kilograms has a blood volume of about 6500 cubic centimeters and when more than 30 per cent (2000 cubic centimeters) is lost without replacement, death will occur. If a large vessel is leaking within the thorax, the doctor must not wait for restoration of blood pressure before considering exploratory thoracotomy. In these cases, everything comes to him who hustles while he waits! Blood and oxygen must be started immediately. There is some question, however, about the use of certain drugs in the shock state. The best drug for constricting the capillary bed seems to be posterior pituitary extract. To constrict the arteriolar bed further by the use of epinephrine is most unphysiologic and tends to increase puddling in the capillary bed, thus, reducing further the volume of blood available for actual circulation. Wiggers[7] has pointed out that during the hypo-reactive stage of shock, vascular structures will not respond to epinephrine and the only function of this chemical at all seems to be that of trapping blood in the minute vessels of the various organs. Epinephrine might conceivably be used where heart action becomes poor but not where the myocardium is involved in the trauma.

Intrathoracic bleeding: A limited collection of blood within the pleural space which does not re-accumulate significantly following thoracentesis is most likely from the lung. Bleeding from pulmonary tissue is usually transitory and will cease as the tissue is compressed by the surrounding collection of blood. Treatment by thoracentesis alone is justified in these cases but, by all means, blood within the pleural space must be removed. Blood accumulating and recurring after removal demands exploration since either an intercostal, internal mammary or hilar vessel is usually involved. Even in the presence of shock, rapid accumulations of blood demands thoracotomy, in which case this procedure has been referred to as the "thoracic autopsy".

Infection: All thoracic wounds, closed or open, are potentially infected. Penetrating wounds carry clothing, skin, et cetera, internally and a wound communicating with a bronchus is subject to infection by organisms normally inhabiting the bronchial tree. Empiric use of antibiotics is mandatory, even in blast injury of the lungs. Antibiotics should be instilled into cavities following each aspiration in addition, and should also be given parenterally. When large quantities of procaine are used, as for local and intercostal nerve blocking, the anesthetic is immediately metabolized to para-aminobenzoic acid and diethylaminoethanol. Para-aminobenzoic acid will inhibit the action of sulfa preparations and so one might avoid their use in such cases. If suppuration has occurred, as within the pleural space, it is most likely that the pH of the medium will be below 7. Streptomycin is inhibited in an acid medium and if used must be incorporated in an alkaline solution, such as sodium citrate, to be effective. Cultures of organisms removed from the thorax can be misleading as a guide to chemotherapy since there is a tendency to loculation of collections of fluid in the pleural space and the bacterial composition of each space may vary widely.

7. Wiggers, Carl J.: *Physiology of Shock.* New York. (1950) Commonwealth Fund.

Pneumothorax and Sucking Wounds: Negative intrathoracic pressure has two functions. One is related to pulmonary ventilation and is responsible for the inspired air. The other is related to the cardiovascular system and is responsible for the return of venous blood to the heart. For the purpose of discussion, traumatic pneumothorax can be divided into two kinds: closed and open, depending upon whether there is an opening in the chest wall. In *closed* pneumothorax, possibly because of the rupture of pulmonary tissue by blunt violence or a fragment of rib, air has leaked from the traumatized lung but the chest wall has remained intact and closed. Usually small holes will seal over spontaneously following some degree of collapse of the lung. Very little or no cardiorespiratory embarrassment will result and the patient is comfortable resting in bed waiting for spontaneous expansion of his lung. On the other hand, the tear may be of such a degree that air continues to leak into the pleural space in spite of considerable or complete collapse of the lung. In this case the relatively sudden increase in intrapleural pressure will cause a tension pneumothorax that forces the heart and other mediastinal structures into the opposite hemothorax. This causes torsion and compression of the venae cavae, decreased return of blood to the heart, diminishes pulmonary arterial flow, decreases output and causes severe compression of the other lung. Unless the patient is quickly relieved of his tension pneumothorax he may die. Management here consists of withdrawal of air and as rapid expansion as possible with realignment of mediastinal structures. If needle aspiration will not suffice because of re-accumulation of air, catheter suction or under-water seal drainage is necessary. If the traumatic fistula fails to close and expansion does not occur it may be necessary to resect the lobe or lung involved.

In *open pneumothorax* the two serious complications, discussed under tension pneumothorax, are produced: impairment of ventilation and venous return to the heart. To what degree the patient is incapacitated will depend upon the size of the hole in the chest wall. If the size of the hole is smaller than the glottis, air *via* the trachea will continue to aerate the lung, in spite of partial collapse, and physiologic impairment is minimal. If the hole in the chest wall is larger than the glottis, the lung collapse will be almost complete and there will be a significant shift of the mediastinum. On inspiration, air will be drawn in through the hole offering the least resistance, the hole in the chest wall in this case, because it is larger than the glottis. The intrapleural pressure will be increased and this increase in pressure will do three things: (1) On inspiration, it will squeeze what little air which remains in the collapsed lung out of the lung and into the opposite lung, thus, the opposite lung will be deriving a good deal of its air supply from the "used air" of the partly collapsed lung. Decreased oxygen intake and hypoxia will result. (2) Shift of the mediastinum towards the good side diminishes ventilatory capacity of the opposite lung. (3) Mediastinal shift impairs venous return to the heart. Severe cardio-respiratory embarrassment and hypoxia result from such a "sucking wound" and in the immediate care of such a case the hole must be plugged with almost anything at hand. Air should be aspirated from the pleural space as soon as possible after closure of the "sucking wound". As quickly as possible after the emergency plugging of such a wound, the hole should be debrided and closed anatomically under sterile conditions.

THE COMPLETE SURVEYANCE

Many severely injured patients are too ill to undergo some diagnostic procedures when first seen. The presence or absence of concomitant injuries of the abdomen, neck and extremities must be determined as early as possible. Several diagnostic points can be established without moving or disturbing the patient unduly. When *abdominal rigidity* is the result of thoracic injury alone, it will be prominent on the side of the injury. The rigidity will be less marked on inspiration. Blocking of the intercostal nerves will cause this rigidity to disappear. An abdomen remaining silent and rigid after a good thoracic nerve block is indicative of intra-abdominal injury. Examine the *neck* for interstitial emphysema. If present, there has been pulmonary, tracheo-

bronchial or esophageal rupture. Try to plot the tract of a penetrating missile. If the patient's condition permits, take *x-rays*. The x-ray is no substitute for clinical judgment; take time to examine the patient first. Upon arrival at the hospital put him to bed or take him to the emergency or operating room; do not allow him to wait around the x-ray department for the technician to arrive so that he can be examined by x-ray first. If possible, obtain postero-anterior, lateral (side of injury) and dorsal decubitus views of the chest. Other films may be indicated.

Thoraco-abdominal Injuries: In these cases, priority should be given the thorax when considering immediate surgical intervention. Abdominal exploration will not be well tolerated by a patient whose cardiorespiratory physiology is not in balance. Many lesions of the abdomen can then be explored and repaired through the diaphragm, the pelvis included. Pressures resulting from forceful trauma of the abdomen can be indirectly transmitted to the thoracic viscera and, therefore, *a survey of the chest is indicated in every case of blunt violence to the abdomen.*

CARDIOVASCULAR INJURIES

Except for the relief of cardiac tamponade and shock, there are no specific first aid procedures to be considered relative to direct injury to the heart and great vessels. Immediate surgical therapy is usually the rule.

Contusion of the heart has been discussed above. Penetrating wounds of the heart result in hemorrhage and pericardial tamponade. If the patient survives the initial injury, several things can happen:

(1) If the wound is small, the resulting tamponade may cause the myocardial bleeding to stop simply by the contained pressure within the pericardium. Treatment consists of aspiration of the hemopericardium.

(2) Bleeding may continue and the tamponade will embarrass the heart. Repeated aspirations result in repeated filling of the pericardial sac with blood from a myocardial wound that will not seal. Exploration is mandatory in these cases.

(3) Blood may leak from the pericardium into one or both pleural cavities. This may result in pulmonary as well as cardiac embarrassment. A patient with significant tension hemopericardium will survive for only a few hours or days and demands immediate aspiration. Immediate relief is the rule following aspiration. As with hemothorax, if blood continues to collect within the cavity following one or two aspirations, exploratory surgery is indicated.

Isolated foreign bodies within the heart structure or chambers should be removed. Unless this is causing hemorrhage or alarming arrhythmia, take time to get the patient into good physical condition before approaching him surgically. If an instrument, such as ice pick or knife, is embedded in the heart through the chest wall, it must never be removed until the heart has been exposed and the proper sutures placed in the heart wall to control the hemorrhage that follows removal of the object.

INJURIES TO LARGE VESSELS

We are concerned here with the intercostal, internal mammary, and great vessels arising from the heart and the hilar pulmonary vessels. Two main types of injury result from the division or rupture of these vessels: (1) "False-aneurysms" which result from hemorrhage into a confined space. In the intercostals and internal mammary vessels, a subpleural hematoma results with delayed secondary hemorrhage. (2) Continued intrathoracic bleeding and progressive hemothorax. Nothing but continued loss of blood results from waiting and these cases demand immediate exploration as previously discussed.

Bleeding from the hilar vessels usually results in immediate death. However, cases of hemo-mediastinum have been recorded with limitation of the hemorrhage within a confined space and "false-aneurysm" formation. This phenomenon gives time to explore but not time to delay since such "aneurysms" have the habit of producing fatal secondary hemorrhage. Bleeding from the subclavian vessels may confine itself in a similar fashion and the bleeding may cease when a local tamponade effect is produced. A very large hematoma may result in compression of other intrathoracic viscera. To maintain ventilatory function or cardiac output, it may then be necessary to aspirate at least some of the "aneurysm". In the case of subclavian injury it is best to wait one to two weeks before exploring. By that time, the divisions of the vessel can be located and controlled without the danger of secondary

hemorrhage produced by opening the area immediately post-injury. In the meantime, antispasmodics and sympatholytic drugs as well as sympathetic nerve block may be resorted to, to encourage collateral circulation to the upper extremity. The formation of arterio-venous fistulae is not uncommon in these cases. Such a defect imposes a severe burden upon the heart. Ligation and excision of the injured vessel with preservation of as many collaterals as feasible is usually the final treatment; few can be repaired by end-to-end anastomosis.

ESOPHAGEAL INJURIES

The esophagus may rupture spontaneously during sudden violent vomiting. Clinically, this must be differentiated from rupture of a gastric ulcer. It is distinguished by the fact that the symptoms follow the retching rather than preceding it as in the case of gastric ulcer. Every patient with a suspected rupture of an abdominal viscus should have a chest x-ray. Traumatic rupture of the esophagus may follow instrumentation by esophagoscope or dilator, swallowing of a foreign body, or as a result of external violence. Basically, the immediate management of ruptured esophagus is the same, be it spontaneous or the result of direct trauma as by instrumentation. Pain may be absent, and rupture following instrumentation may not be detected until an x-ray reveals mediastinal emphysema or interstitial emphysema appears clinically. Usually spontaneous rupture is a very violent affair, pain being severe and constant, radiating across the upper abdomen and lower chest into the back. Some degree of shock, and dyspnea and cyanosis may be present. Swallowing food or fluids accentuates the symptoms. Within a few hours, the localized mediastinal collection of fluid ruptures into one or both pleural spaces, usually the left, and the picture becomes further complicated by the pleural effusion. The diagnosis is confirmed by a small amount of lipiodol by mouth finding its way into the mediastinum or pleura. The immediate management of a case of esophageal rupture following diagnosis will determine the eventual outcome. Delay in these cases is associated with a very high mortality. All such patients should be hospitalized, and antibiotics, (streptomycin and penicillin) started at once. If the diagnosis is made within six to eight hours and the patient can tolerate surgery, the chest should be explored and primary suture of the opening be attempted followed by catheter suction of the involved pleural space and mediastinum for a number of days. If the diagnosis has been retarded beyond eight hours, primary suture will usually be followed by sloughing at the suture line and esophageal fistula. These "retarded" cases should be treated by catheter suction of the pleural space involved and mediastinum in the area of rupture. The fistulous opening will often seal spontaneously if the patient survives the infection. Secondary closure may be attempted if a persistent fistula can be demonstrated by repeated lipiodol studies. In all cases, gastric suction should be instituted immediately following diagnosis and the maintenance of fluid balance begun by intravenous fluids, blood, plasma, et cetera.

CHYLOTHORAX

Interruption of the thoracic duct may result from necrotizing lesions such as tuberculosis, carcinoma and infection or by direct injury. A large lymph vessel traversing the thorax may become a very friable structure by becoming involved in one of the infiltrating lesions mentioned. Sudden violent cough producing rapid changes in intrathoracic pressures or violent jarring against adjacent structures may cause rupture of such a vessel resulting in a persistent leakage of chyle into the pleural space. Direct violence by weapon or fracture of the first rib may tear into the duct. The relatively infrequent incidence of this type of injury is accounted for by the location of the ductile system deep in the thorax and its environment of surrounding soft protecting structures. The diagnosis of injury to the thoracic duct is made by the aspiration of milky chyle in a case of pleural effusion. Since between 1500 and 2400 cubic centimeters of chyle flow through the thoracic duct within 24 hours, extensive pleural collections may occur and repeated aspirations will then be necessary. This means severe depletion of nutritional elements. Of all protein losses, albumin depletion is the most rapid and severe since the lymphatic sys-

tem collects albumin from all interstitial spaces throughout the body. There is also a marked depletion of lymphocytes from the blood since the lymphatic system is responsible for the transport of these cells back to the blood stream. Chylothorax demands vigorous replacement of nutritional elements (proteins and vitamins in particular) and rapid closure of the defect. Repeated aspirations may bring about closure of the defect, if intrathoracic, by re-expansion of the lung and compression of the injured region. This is not the rule, however. If repeated thoracenteses reveal no tendency for the flow of chyle to diminish, it will be necessary to ligate the ductile system. If the defect is in the neck (in the region where the thoracic duct empties into the subclavian vein) exploration of this area may make ligation possible. However, this is impractical if necrotizing lesions have infiltrated this region and it will be necessary to ligate the thoracic duct immediately below or above the diaphragm. There are adequate collaterals in this system and apparently there is little difficulty in returning chyle to the venous circulation through collaterals to the right lymphatic duct, azygos, intercostal, renal, iliac and portal veins, and the inferior venae cavae. Since atropine diminishes lymphatic flow by blocking vagus impulses (which give these vessels tone), atropine may be given to reduce the pressure and flow within these vessels during attempts to arrest the leakage of chyle.

BLAST INJURIES

The effects of the sudden changes in intrathoracic pressures produced by the compression and decompression waves of a blast will depend not only upon the nature of the force but also upon the position of the individual in relation to the origin of the blast. It is not necessarily true that the nearer one is to the origin of the pressure wave, the more injurious will be the blast. During the initial compression phase, the thoracic wall and diaphragm strike the viscera of the thorax producing local rupture of blood vessels and alveoli within the periphery of the lung. Following the decompression wave, there is a sudden pull upon the chest wall causing a suction effect upon the lungs, rupturing bronchioles, alveoli and small intrapulmonary vessels.

In severe cases, shock, dyspnea, cyanosis, cough and frothy, bloody sputum are the presenting clinical features. Hemoptysis is the most constant feature.[8] Extensive injury, however, may be present which may not be manifest for several days.[9] The soft tissues of the chest may be severely contused and lacerated, and the impact of the ribs upon the surface of the lungs may leave ecchymotic imprints. Extravasation of blood may be considerable. Management includes the treatment of shock, maintenance of an airway and supply of oxygen, and intensive antibiotic therapy.

Never hesitate to perform tracheotomy in a case of this sort. This will reduce the dead space through which respiratory effort is wasted in bringing air into the lungs; it will provide an easy route for repeated aspiration of blood and secretions, as well as for oxygen. Even positive pressure oxygen can be given through a tracheotomy tube. The importance of alleviating pain and restoring blood volume in the management of shock must again be stressed. The torn and contused parenchyma offers a perfect culture medium for bacteria. Early and intensive antibiotic therapy should be employed using several agents to cover a broad spectrum of microorganisms.

CONCLUSION

A brief discussion of the basic problems met with and an outline of the management of trauma to the thorax is presented. Emphasis is placed on immediate action in the care of the severely injured chest as a substitute for the too frequently encountered "do nothing" or "watch and wait" method of practice. It is often amazing to see patients inflicted with severe trauma successfully ride out their difficulties under improper management. It is less startling, but more satisfactory, however, to realize that "everything comes to him who hustles while he waits".

8. Sealy, W. C.: Archives of Surgery, 59:882 (1949).
9. Hochburg, Lew A.: *The Thoracic Surgical Patient*, New York, (1952). Grune & Stratton.

710 Grand Avenue

THE CROSS-EYED CHILD*

R. D. Harley, M.D., Atlantic City, N. J.

The Conservation of Vision Committee has recently launched a program consisting of talks on "Your Child's Eyes" before Parent-Teacher groups. Early treatment for the cross-eyed child is stressed. By means of such talks before interested adult audiences, and through cooperation of the family physician, treatment may be extended to the strabismic child in the pre-school period.

The ideal time to begin correction of convergent strabismus is immediately following recognition of the ocular disability. Study of 100 cases showed that in thirty of these, a period of two to five years had elapsed before the strabismus was brought to the attention of an eye physician. What accounted for this delay? Reasons given by the parents fell into three categories: (1) Parents' failure to recognize the crossed-eye. (2) Acceptance of advice to wait. (3) Parents' or relatives' fear of operation. The problem of the cross-eyed child begins with the parents in many cases. There is an increasing tendency for the discussion of such subjects in popular magazines but unfortunately the facts fail to reach many who need the information. The urgency for the early recognition and the treatment of strabismus cannot be overstressed if we are to obtain good functional results. The family physician and the pediatrician play a vital role in instructing the parent and guiding the cross-eyed youngster to the ophthalmologist.

Mothers and fathers quite naturally want their children to be perfect. It is always a shock to them to find that their child's eyes are crossing. The eyes of a new born infant may cross periodically or even diverge. This may occur normally up to the age of six months. About this time, the eyes should begin to exhibit coordination and parallelism in the "eyes front" position as they begin to study everything in their vicinity. If a child's eye remains crossed beyond this time it signifies a real disability and demands attention. Many parents fail to recognize that the child's eye is crossed and valuable months of treatment time are lost. Frequently a relative or neighbor is the first one to suggest that the eyes are not functioning together and the parents are then urged to seek medical advice.

Many years ago we frequently heard the suggestion "Don't worry yourself about it, the child will grow out of it". This dangerously wrong advice is not so common any more for it has resulted in many useless eyes. Fewer than one per cent of children who are really cross-eyed ever "outgrow" the defect. The child's eyes, left unattended, will show some permanent defect in most cases.

One report we commonly hear from parents is that the child had perfectly straight eyes until the age of two or three when, following a childhood illness or a "bad fright", the eyes began to cross. This observation may be entirely correct. It usually indicates to the doctor that the eyes were on the verge of crossing and needed but some minor disability to precipitate an event which was quite likely to happen at any time. Then there is another type of crossing which shows up only after fatigue or following an emotional upheaval. This "intermittent strabismus" frequently progresses to a permanent crossed condition.

Let us suppose, that the parents decide to wait and see if the child will outgrow its crossed eyes. What happens? Aside from the eye disability there occurs significant changes in the child's personality. The child with crossed eyes is obviously different from his playmates. Children are quick to recognize even the smallest change in the normal pattern of other people. They are often unconsciously cruel as they quite openly discuss such defects among themselves. Descriptive nicknames are given to their unfortunate playmates who are different in having crossed eyes.

*Abstract of radio address presented under the auspices of the Conservation of Vision Committee of the Atlantic County Medical Society in January 1952. The Committee on Conservation of Vision suggests that this paper may serve as a guide to any physician called to speak to a civic group on this subject.

The cross-eyed child reacts in one of two ways to this severe emotional experience. He withdraws from his group, becomes shy, timid and spends his time with books or in games where he can be master through his own imagination. He suffers from a real sense of inferiority and of "not belonging". Or he becomes loud, boisterous and aggressive, particularly with children younger than himself. He attempts to compensate by assuming qualities which the others do not have or display. Either mechanism for an altered personality may continue into adult life and become permanent if the defect is not corrected.

The eyes of the new-born are frequently observed to lack coordination and cross. Even after coordination is present, the infant's vision is not fully developed. Acuteness of vision develops steadily for the first five or six years of child's life. It requires this time and normal use for the full development of 20/20 sight. If the coordination of the eyes during this critical developmental period is poor, then one of the eyes frequently remains at a sub-normal visual state. We call this faulty sight amblyopia, or weak sight. Others speak of it as a "lazy eye". This "laziness" was really forced upon it. If this poor vision or amblyopia is permitted to remain without treatment beyond the age of six it usually becomes permanent and the sight remains about 20/200 for life. Treatment is by occlusion or blocking off the good eye with a patch or an opaque lens. This forces the poor eye to work. The earlier occlusion is begun, the sooner the poor eye responds and the more likely we are to obtain normal vision.

Correction of amblyopia in the pre-school child is the most important single therapeutic objective. The final functional result obtained through the use of prescription lenses, exercises or surgery is primarily dependent on the establishment of equal and normal vision in both eyes. The numerous factors involved in binocular vision all depend on good visual acuity.

The infant's eyes are usually far-sighted. It requires the extra effort of accommodation or focusing on the part of the eyes to achieve a clear image. During the process of focusing or accommodating on close objects, the eyes converge. In the very far-sighted eye the tendency to converge is even greater. Since the cross-eyed child is frequently very far-sighted, there is a strong tendency to over converge.

The basic trouble seems to be a faulty or weak "fusion" power. By "fusion" is meant the ability of each eye to look at an object so that each eye receives an image that corresponds to that seen by the other eye. This image picture is relayed to the brain where a single picture is developed and "fused" under normal conditions. If the eyes do not receive a corresponding image for fusion, the brain records two objects. The person then sees double. Then one image must be suppressed. This often takes place in one eye of the cross-eyed person. The familial occurrence of crossed eyes has long been known. Several factors are involved; an inherent difficulty with fusion is one of them.

Treatment for the cross-eyed child should begin immediately after the condition has been noticed. In general, there are three basic methods for treatment; the use of prescription lenses (with or without patching one eye), eye exercises and surgery. Each case is an individual problem and may be handled by one, two or all three of the methods. Satisfactory results may be anticipated upon the establishment of parallelism and the development of fusion.

Far-sightedness can be corrected with glasses which eliminate the need for excessive focusing. If the crossing of the eyes is due to far-sightedness entirely, corrective lenses may straighten the eyes satisfactorily. If, however, far-sightedness is only a precipitating factor and not the entire cause, glasses will only partly straighten the eyes. The remainder of the crossing requires correction by other methods. The eye which remains consistently crossed for any length of time frequently has subnormal sight. Before anything further can be done it is important to restore the sight in the crossed eye which is otherwise healthy. If the child is forced to use the "weak" eye by completely patching the other eye, vision may be restored when this procedure is started before the age of five or six. When good sight is present in each eye and prescription glasses

fail to straighten the eyes entirely, then an operation is almost invariably required to complete the cure.

We are frequently asked about the advisability of eye exercises. Under the guidance of trained personnel such as an orthoptic technician, eye exercises are useful in the correction of a number of visual and eye muscle defects. But, contrary to some writings on the subject, they are not cure-alls. Eye exercises will never restore normal sight to those suffering from any eye disease; and they will not enable all wearers of glasses safely to throw their spectacles away. Eye exercises do not correct refractive error or so call "color blindness". Orthoptics is the name given to the procedure which aims for single binocular vision by the stimulation of fusion and the coordination of eye movements. Exercises may range from simple ones, performed at home, to complex ones requiring the use of elaborate and expensive machines supervised by professional technicians. Orthoptic exercises are in essence, educational methods whereby a poorly developed fusional apparatus is stimulated to normal function.

When surgery is indicated, it is essential that it be accomplished as soon as possible. Best functional results are obtained before the child has entered school. Surgery aims at one specific effect: to place the eyes in a good position so that the reflexes for coordinated vision may work more advantageously. When muscle surgery is done in later years, the eyes can still be straightened satisfactorily but the functional result leaves much to be desired. The operation is not particularly difficult or dangerous. General anesthesia is usually employed for children but adult muscle cases are frequently done under local anesthesia. The eyeball itself does not have to be opened. All operations on eye muscles, no matter how elaborate the medical name given to them, are either shortening or lengthening operations on the extraocular muscles. The operation will not affect the vision in either eye. The question is frequently asked, "Can my child go without glasses after the operation?" The answer depends largely on the refractive error or the degree to which the eyes are dependent on lenses for adequate sight and relaxation of the eyes. Each child presents an individual problem. Most eye physicians are guarded in their answer as to the future need of glasses.

There is a general agreement among those who are best qualified that children with cross-eyes should have their eyes straightened early in life. Just as you would correct a child's lame leg when possible before he learns to walk, so would you correct a child's crossed eyes before he needs to use them together as a team. This goal is attainable for virtually every cross-eyed child who is handled in a manner consistent with present day concepts.

101 South Indiana Avenue

AMERICAN CONGRESS OF PHYSICAL MEDICINE

The annual session of the American Congress of Physical Medicine will be held this August at The Roosevelt Hotel, New York. Scientific and clinical sessions will be given on the days of August 25, 26, 27, 28 and 29. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists registered with the American Registry of Physical Therapists or the American Occupational Therapy Association. Full information may be obtained from the American Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Ill.

CARDIAC EMERGENCIES *

Arthur Bernstein, M.D., Newark, N. J.

SYNCOPE

Syncope is essentially caused by cerebral anoxemia. In the first stage the patient feels dizzy, light headed, has spots before the eyes, and feels faint. In the second stage, he faints. The third stage, which follows when the anoxemia lasts over fifteen seconds, results in convulsive seizures. This is a protective mechanism to increase the blood supply to the vital centers.

Local causes for syncope include brain abscess, brain tumor, or other brain disease; and diminution of cerebral blood flow due to vascular changes. Cardiac causes for syncope may be *primary* (such as disease of the sino-auricular node or the auriculoventricular node, ectopic rhythms, myocardial infarctions, dissecting aneurysms, cardiac tamponade, aortic stenosis, mitral stenosis with a ball-valve thrombus and congenital heart disease with a reversal of the shunt) or *secondary* cardiac causes due to reflex mechanisms mediated through the vagus. Three types of vagal reflexes come in the play: one is the so-called *cardio-inhibitory* type which results in a fall in blood pressure and either a slow heart rate or complete asystole. Another and rarer type of vagal reflex is the *vasodepressor reflex*. In this type of syncope there is a fall in blood pressure without change in the pulse rate. Finally there is the *cerebral type* of vagal reflex with syncope without fall in blood pressure or change in pulse rate.

The third group of cardiac causes for syncope is a combination of primary and secondary factors such as are seen in aortic stenosis. The fourth group of causes for syncope are *postural*. These are of two types—the *vasodepressor type* which is the most common cause of syncope and is popularly known as "fainting" in which there is a drop in blood pressure and a fall in pulse rate to 40 or 50 beats per minute. This type of syncope is not related to vagal tone and is not influenced by atropine. *Postural hypotension* is also seen. The fifth group is made up of *extrinsic causes* such as drugs, anoxemia, shock, hemorrhage and hyperventilation.

Treatment of the secondary types of cardiac syncope consists in an attempt to remove the cause for vagal stimulation. The patient must not wear tight collars if he has a hyperactive carotid sinus reflex. Diverticuli of the gastrointestinal tract (particularly of the esophagus) should be removed or medical treatment directed towards preventing them from becoming inflamed or distended. Atropine in large doses is effective under some circumstances. Sympathomimetic drugs such as ephedrine sulfate, amphetamine and dextro-amphetamine may also be used. Procaine infiltration of the vagus has been effective in some few cases. Cutting the carotid sinus nerve unilaterally or bilaterally has been recommended with varied results. The glossopharyngeal nerve has been cut centrally in an attempt to break the reflex chain. This has not been particularly successful.

Postural hypotension which results from loss of sympathetic tone is seen generally in patients with tabes dorsalis, Addison's disease and after Smithwick operations, poliomyelitis and after prolonged bed rest. These patients will often be helped by moving around or by changing from the recumbent to the upright position slowly. At times, sympathomimetic drugs may be a necessity. Some of these patients must bandage their legs and use abdominal bandages before they get out of bed in order to prevent loss of consciousness.

CARDIAC ARREST

Cardiac arrest may result from arteriosclerosis with involvement of the auriculoventricular node, from vagal reflexes, anoxia, or anesthetic overdosage. It may occur as a result of operative procedures particularly those in the thorax where the vagus may be stimulated. The diagnosis is readily made by auscultation or by feeling the heart if the patient is on the operating table. It must be differentiated from ventricular fibrillation either by the use of the

*Read before the Ocean County Medical Society, Toms River, N. J., February 13, 1952.

electrocardiograph or palpation. In cardiac arrest, palpation will reveal no heart beat; in ventricular fibrillation the heart will feel "like a bag of worms" to the examiner's hand. Medical *treatment* of cardiac arrest consists in the immediate use of oxygen and artificial respiration. The brain must be oxygenated in three to four minutes or permanent cerebral damage will result. Mouth-to-mouth insufflation should be used if no other means is available. An anesthesia bag with a tight fitting mask and oxygen are particularly good. The injection of epinephrine into either the cavity of the right ventricle or into the myocardium itself has been recommended for many years. It is best injected by using a long needle (3 to 4 inches) attached to a syringe into which has been drawn some 1:1000 epinephrine solution. The needle should be introduced in the fourth interspace at the left sternal margin and inserted until blood can be drawn into the syringe. The epinephrine is then injected. Until epinephrine has been made available it may be advisable to resort to the old remedy of rhythmic thumping on the chest wall with the fist. Rapid transfusions of blood or plasma may also be of help.

If a surgeon is available, he should make an immediate incision into the fourth interspace from the left sternal border to the midaxillary line. The surgeon then inserts his hand and grasps the heart and begins a rhythmic pumping while oxygen is being administered. The ideal rate is 120 beats per minute. If this is too tiring to the operator, the minimal rate should be between 60 and 80 per minute. In manual pumping, the heart may be grasped in one hand and "pumped" if it is small. However, in most cases two hands must be used—one behind and one in front of the heart.

Transfusions of blood or plasma should be given at the same time. At times it is wise to clamp off the abdominal aorta so that all the blood is deviated to the brain for a short period of time in order to rapidly oxygenate the cerebrum.

If ventricular fibrillation is present, procaine amide[1] should be given intravenously, if there is any circulation at all; or it may be injected directly into the heart, on the heart, or in the pericardium. Electric countershock using 60 cycles of alternating current and developing 1½ amperes should be used to stop the fibrillation. At times it is necessary to use more than one shock at intervals to produce the desired effect.

Stokes-Adams attacks may be due to cardiac standstill, ventricular standstill with continuation of the auricular beat, prefibrillatory type of rapid ventricular tachycardia, ventricular fibrillation or a combination of any of these. In treating Stokes-Adams attacks, the physician may "thump" the precordium, giving epinephrine by intracardiac injection when he is sure that it is cardiac or ventricular standstill with which he is dealing. In ventricular fibrillation or ventricular tachycardia, epinephrine is not the drug of choice. Under these circumstances, papaverine in doses of from 1 to 3 grains may be of help. Procaine amide[1] in doses of from 500 to 1000 milligrams may be life-saving. Between attacks ephedrine in doses of from ⅜ to ¾ grain may be particularly effective in preventing further attacks. Procaine amide[1] may also be used prophylactically in doses of 250 milligrams four times a day or more as needed. Digitalis must be used when there is evidence of heart failure, in spite of its theoretical contraindication.

PULMONARY EMBOLISM

Pulmonary embolism is another form of cardiac emergency with which one deals both on medical and surgical wards as well as in the home. Pulmonary emboli generally come from the lower extremities and usually follow pelvic surgery, deliveries, or prolonged stays in bed in older individuals particularly in those with varicose veins. Usually the patient becomes dyspneic, cyanotic and restless; he complains of severe substernal pressure. Shock and death may occur rapidly. The differential diagnosis from myocardial infarction, dissecting aneurysm and spontaneous pneumothorax may be difficult. The history, x-ray findings and electrocardiogram may be helpful. In the treatment of this condition oxygen is most important. Morphine grain ¼ to ½ combined with atropine grain 1/75 to 1/150 will help

1. Available as Pronestyl Hydrochloride, distributed by E. R. Squibb and Sons.

relieve pain and reduce vagal reflexes. Vasodilator drugs such as papaverine, in doses of 1½ to 3 grains, or aminophyllin in a dose of 7½ grains may be given intravenously as vasodilators. Atropine, grain 1/100 may be given intravenously to reduce the reflex spasms produced by vagal mechanisms. The use of the anticoagulants, particularly heparin for its rapid action, need not be discussed here. Ligation of the leg veins or of the inferior vena cava may be indicated at times but with adequate use of the anticoagulants this is rarely needed now. Prophylaxis may prevent the development of pulmonary emboli in many cases where such a complication would be anticipated.

CARDIAC TAMPONADE

Acute cardiac tamponade may be seen following injury to the heart, pericardium or great vessels. It may follow stab or gunshot wounds or chest injuries in automobile accidents or may result from acute infections with rapid sudden effusion into the pericardial sac. Rupture of the heart after myocardial infarction and dissecting aneurysms of the aorta with rupture into the pericardial sac as well as sudden hemorrhage into the pericardial sac in hemophilia may also produce cardiac tamponade. These patients are generally in shock when first seen, with a weak thready pulse usually paradoxical in type. The blood pressure is low and veins of the neck are distended. The heart sounds are distant or inaudible. Dyspnea and cyanosis are usually present as well as an enlarged cardiac silhouette or heart enlargement on percussion. The liver may be palpable since it is often depressed by the enlarged heart. The electrocardiogram will show the changes of pericarditis. Immediate treatment demands aspiration to relieve the pressure in the pericardial sac and so permit filling of the right auricle. When the pressure in the pericardial sac exceeds that of the right auricle, symptoms occur. Often one tap is sufficient to relieve the pressure; otherwise further tapping or even operation may be necessary. Intravenous blood or other fluids are sometimes helpful by increasing the venous pressure and so overcoming the pressure engendered by the fluid in the pericardium.

PERIPHERAL EMBOLI

Rheumatic heart disease with fibrillation and coronary thrombosis produce 70 per cent of the peripheral emboli. These emboli usually lodge at bifurcations of the peripheral vessels. The symptoms are those of sudden violent pain and/or coldness and/or numbness of an extremity as well as pallor in the first one or two hours followed by dusky or blue color in five or six hours. There may also be loss of some sensation, paralysis of muscle movement, and tenderness over the muscles. Embolism must be differentiated from thrombosis. The treatment consists essentially in first doing a paravertebral block. In addition, the patient may be given 25 to 50 milligrams of benzazoline[2] intramuscularly. Two ounces of whiskey should be given and repeated every hour. The patient should be kept warm with blankets and a cradle with a thermo-regulator kept at 90 degrees should be placed over the body. The leg must not be elevated. At the end of two hours if the pain is severe and the patient can't move the foot or toes and the foot is cold and blanched, an embolectomy should be done. If there has been improvement, heparin and Dicumarol[3] should be given following the usual routines. In addition, benzazoline[2] may be given by mouth, 50 milligrams, every four hours, and papaverine, grains 1 to 3 may be given intravenously. Once anticoagulants have been started, paravertebral block should not be done because of the danger of hemorrhage.

ACUTE LEFT HEART FAILURE

Acute left heart failure is probably one of the most common cardiac emergencies the doctor sees. In a thousand cases of acute heart failure, hypertension with and without coronary artery disease was the most common underlying etiologic factor. Next in frequency was coronary artery disease with and without hypertension. Rheumatic heart disease, syphilis, toxic conditions, congenital heart disease and myocarditis follow in that order. In treating acute left heart failure, morphine in doses of ¼ to ½ grain are given to relieve appre-

2. Marketed by Ciba Pharmaceuticals under the name of Priscoline.
3. Collective registered trademark, Wisconsin Alumni Research Foundation.

hension and to sedate the patient. Atropine, 1/100 to 1/150 grain should also be used in an attempt to reduce the Hering-Breuer reflex and so help the patient's breathing. In many cases these two drugs alone will suffice to stop the attack.

However, oxygen therapy is also most important. The best means of delivering oxygen is by positive pressure using 5 centimeters of water to begin with and gradually reducing this to 1 centimeter. When a mask is not available or when the patient is uncomfortable in a mask, a tent should be used. With a tent, 10 to 12 liters per minute should be used to obtain adequate oxygen concentration. With a nasal catheter in the nasopharynx, one is able to achieve only a 40 per cent oxygen concentration with a flow of 7 liters of oxygen per minute. It has been recommended that with the oxygen therapy, the doctor bubble the oxygen through 40 per cent ethyl alcohol. The alcohol is an "antifoaming" agent and thereby increases the amount of oxygen absorbed. This method is new and whether other agents will be better or whether this concentration of alcohol is the ideal one has not been settled as yet. However, in some cases it may be of help.

In some patients in acute left heart failure, digitalization is necessary. Under these circumstances Cedilanid[4] intravenously in a dose of 1.6 mgm. is a digitalizing dose under most circumstances for the average adult. Before giving this dose it should be determined that the patient has had no digitalis for at least one month. If there is any doubt, it is best to give 0.8 milligrams of Cedilanid[4] intravenously and then repeat it in 4 to 8 hours. Digitalization may then be continued by mouth.

Phlebotomy may be of value especially if the patient has large distended veins and a full pulse while in failure. This should not be performed if there is any question as to whether the patient has an anemia; or if it must be repeated. One may do a "bloodless phlebotomy" with the use of tourniquets on the four extremities. With this technic, the therapist uses either blood pressure cuffs or rubber tourniquets applied tightly enough to prevent venous return but not to prevent the in-flow of arterial blood into the four extremities. In this way blood is "trapped" away from the heart, reducing the volume of blood returning to the right heart and so helping compensation. One extremity at a time may be released after fifteen minutes to prevent damage to the limb.

The mercurial diuretics should also be used in the treatment of acute left heart failure. It was at one time believed that they increased blood volume and were therefore dangerous to use under these circumstances. This is not so and there are few real contraindications to their use. Intramuscularly in 1 or 2 cubic centimeter doses, they will begin to cause a diuresis within 1 to 2 hours and will be helpful in the relief of left heart failure. They may be given intravenously if very rapid action is desired.

MYOCARDIAL INFARCTION

Acute myocardial infarction has become more and more common and is an emergency of great seriousness. Treatment consists essentially in the use first of morphine to relieve pain in doses as previously recommended under the treatment of heart failure. When pain is severe, morphine intravenously in doses of ⅛ to ¼ grain may be particularly effective. Atropine should also be used in the doses previously recommended. Oxygen therapy should be utilized as outlined in the treatment of heart failure except that "antifoaming" agents have no place unless the patient goes into heart failure. Papaverine may be given intravenously in doses up to 2 grains, if a patient is not in shock, and that may help relieve pain. Aminophyllin, grains 7½ intravenously has also been recommended. It increases the work of the heart and has been blamed for some deaths. If used, it should be diluted and given in 200 cubic centimeters of 5 per cent glucose by drip. The use of 50 per cent glucose is *not* recommended. If shock accompanies the myocardial infarction, certain further measures may be necessary. Some have recommended sympathomimetic drugs to raise the blood pressure such as epinephrine, ephedrine, and/or neosynephrine.[5] However, there is much controversy about these preparations because of their side effects which may be fatal. The ad-

4. Tradename registered by Sandoz Pharmaceuticals for a brand of Crystalline lantoside.
5. Tradename registered by Winthrop-Stearns, Inc.

ministration of whole blood or plasma, either intravenously or intra-arterially, has also been recommended. Results here have not been as gratifying as we would like. Nonetheless, when a patient with myocardial infarction goes into shock, the use of plasma or whole blood intravenously or intra-arterially may be life-saving.

Some have recommended quinidine prophylactically to prevent the development of arrhythmias. However, it is probably best to use this drug only when needed. Digitalization should be utilized in the event of acute left heart failure but it must be remembered that the minimum lethal dose is reduced to one-half in the presence of myocardial infarction. The use of the anticoagulants need not be discussed here.

ARRHYTHMIAS

Generally speaking, with rapid heart rates the patient exhibits palpitation, faintness, dizziness, light headedness and, at times, actual fainting. Throbbing in the head, throbbing in the neck, a feeling of pressure in the precordial or substernal region, shortness of breath and even shock may develop if the rate is fast enough or if there is underlying heart damage. With slow heart rates, the patient may complain of dizziness and faintness. In irregular beating of the heart in addition to any of the other symptoms, the patient may state that "the heart feels as if it is turning over" or that there is an irregular thumping. Ectopic rhythm must be considered as a diagnostic possibility if any of the following are found:

(1) Any irregularity.
(2) A rate below 30 or above 140 with a regular rhythm.
(3) A history of a sudden onset of a rapid rate.
(4) A rapid rate with heart failure.
(5) When the rate may be halved by carotid sinus pressure.
(6) When there is variation in the intensity of the heart sounds with the rapid rate.
(7) When the rate does not vary in its rapidity from moment to moment or after exercise.
(8) Typical electrocardiographic findings.

In *paroxysmal auricular tachycardia,* the patient will complain of a sudden onset of a rapid rate with any of the symptoms mentioned above that accompany rapid rates. Usually these patients will also have had previous attacks of rapid rate with sudden onset and sudden offset. The rate ranges between 150 and 200 beats per minute, though in the less common type of paroxysmal auricular tachycardia the rate may be 75 to 100 because of a two-to-one block. If there is underlying disease (such as arteriosclerotic cardiovascular disease) signs of heart failure and often the electrocardiographic evidences of coronary insufficiency may be found. Diagnosis is made by the electrocardiogram. Clinically it must be differentiated from simple tachycardia, auricular flutter and ventricular tachycardia. Of these three, paroxysmal auricular tachycardia is the only one which responds to carotid sinus pressure by a sudden halving of the rate with a restoration of the normal mechanism which is usually maintained for a long period of time.

Many paroxysms can be stopped if the patient causes himself to gag or vomit. This may be done by the use of the finger or by any of the emetics. However, the best method is by carotid sinus pressure. The patient lies flat in bed. The physician places his stethoscope on the chest and then applies pressure to the carotid sinus on one side only. Pressure is maintained until there is a change in the rate or the heart stops beating and then the finger is immediately removed. Never press on both sides at the same time. If pressure on the right side is ineffective, the left side should be tried before giving up. If this fails, one may get results by giving the patient a cubic centimeter of a 1 to 2000 solution of neostigmine[6] intramuscularly. This may in itself stop the paroxysm but usually it is necessary to wait twenty minutes after the injection of neostigmine[6] and then repeat the carotid sinus pressure. Usually this will be effective if previous pressure was not. Another drug which has been used but which is not particularly recommended for the treatment of this condition is methyl choline,[7] 25 to 50 milligrams subcutaneously. Though this drug will very frequently be effective, its side effects are so upsetting that it should not be used except as

6. Available under the trade-name, Prostigmine (Hoffmann-LaRoche).
7. Tradenamed as Mecholyl (Merck).

a last resort. When it is used it should never be given until a syringe containing 1/50 of a grain of atropine sulphate has been prepared and is ready for immediate use to counteract the side effects of the methyl choline.[7] Some cases of paroxysmal auricular tachycardia are best helped by intravenous Cedilanid.[4] This may be given in a dose of 1.6 milligrams intravenously, which is a full digitalizing dose. However, if there is no great amount of failure one may give one half this dose and then repeat it at intervals until the paroxysm stops. One may also give digitalis intramuscularly in a dosage of two or three cat units every two hours until the desired effect is achieved. Quinidine sulphate in doses of 5 grains intramuscularly every hour for five or six doses has also been effective in some cases. Procaine amide[1] (250 to 500 milligrams every four hours by mouth) has also stopped these paroxysms in some cases. At times 10 cubic centimeters of magnesium sulphate in 10 per cent solution intravenously has also stopped a paroxysm. Between attacks, find the precipitating factor, and treat that. Some patients are best maintained on digitalis continuously thereafter to prevent attacks if they come on frequently enough.

Paroxysmal ventricular tachycardia is not a common arrhythmia but it is a frightening one when it occurs since it is usually seen with cases of myocardial infarction. Six or more ventricular extrasystoles in succession may be defined as a bout of paroxysmal ventricular tachycardia. These paroxysms may last a few hours, days or weeks. Its chief danger is its tendency to predispose to ventricular fibrillation which is practically incompatible with life. Furthermore, there is a tendency to rapid exhaustion of the heart muscle. Since it is usually seen as the result of toxic digitalis effects, myocardial infarction and/or severe grades of hypertensive and arteriosclerotic heart disease, it is a grave emergency. The symptoms of ventricular tachycardia are those of any ectopic rhythm as previously oulined but are likely to be more severe, often complicated by heart failure and shock because of the associated damage to the heart. The diagnosis is usually made clinically in the presence of known heart disease and a ventricular rate of 130 to 180 per minute which does not yield to carotid sinus pressure. Further, there is usually a slight irregularity of the ventricular rate in these cases and a variation in the intensity of the heart sounds because of the super-position of auricular and ventricular contractions in different cycles. Electrocardiographically, the diagnosis is made on the fact that the beats of the paroxysm must be ectopic in origin and must conform to those observed as isolated ventricular extrasystoles before the onset of the paroxysm. The first beat of the paroxysm must bear the same relation to the preceding normal beat as a coupled extrasystole bears to the preceding beat. The auricles and ventricles must beat independently of one another. Occasionally esophageal leads are needed to establish a diagnosis. Four types of ventricular tachycardia are seen electrocardiographically:

(1) Runs of ventricular extrasystoles, all beats having the same configuration, rate between 130 and 180 per minute.
(2) Bi-directional ventricular tachycardia, usually a toxic effect of digitalization.
(3) Markedly aberrant widened QRS complex, seen immediately before, or just on emerging from Stokes-Adams seizures.
(4) Rate between 200 and 250, wider and more bizarre complexes with helix-like undulations: "prefibrillatory ventricular tachycardia".

The treatment of choice for this condition is procaine amide.[1] It is given in doses of 500 to 1000 milligrams every two to four hours orally. However, if a rapid effect is desired it may be given intravenously at a rate of 100 milligrams every two to three minutes until either a sinus rhythm is restored or one Gram has been given or toxic effects are noted either on the electrocardiogram or clinically. After the restoration of the sinus rhythm ¼ to 1 Gram may be given by mouth every four to six hours. Quinidine sulphate was for many years the drug of choice. The dose by mouth or intramuscularly ranges from three to five grains four to five times per day. At times it is necessary to use doses up to 10 grains every hour for five to ten doses. The intramuscular route is used when there is some shock and there is reason to feel that absorption by mouth may be uncertain. Quinidine

hydrochloride may be given intravenously in 5 grain doses diluted in 20 to 50 cubic centimeters of normal saline. Though procaine amide[1] is effective in about one-half to two-thirds of the cases if it is given in adequate dosage, other drugs such as potassium chloride, 2 Grams every two to four hours may be necessary. Atropine sulphate (in doses of 1/30 of a grain subcutaneously) has also been used. Magnesium sulphate, 15 cubic centimeters of a 20 per cent solution, has been given intramuscularly in an effort to stop paroxysms. Papaverine in doses 200 to 300 milligrams every three hours has also been reported to be effective.

Auricular flutter is usually seen in patients with moderately advanced or severe grade of myocardial involvement in middle or older age groups. It is rarely observed in normal hearts. The symptoms are those of any rapid heart rate. Mental disturbances of varying degrees of severity have been observed in about 10 per cent of cases. The ventricular rate may vary greatly depending upon the amount of block at the auriculoventricular node. If the rate is rapid, a pulse deficit may be present. With slow rates one may at times hear the auricular beats. With a rapid one-to-one flutter the heart muscle becomes rapidly exhausted and heart failure and shock may result. Carotid sinus pressure in auricular flutter results in either no ventricular slowing or if it is produced it is maintained only during the period of carotid sinus pressure. The diagnosis is best made with the electrocardiogram. In the treatment of auricular flutter, digitalis is the drug of choice. It will break up the flutter in about 70 per cent of patients. Usually the flutter is first converted to auricular fibrillation. The digitalis is then stopped and after a period of one to fourteen days the fibrillation will revert spontaneously to a regular sinus rhythm in two-thirds of the patients. If at the end of two weeks the fibrillation still continues, quinidine may be tried in an effort to convert the fibrillation to a normal rhythm. The dosage of digitalis is the same as that mentioned under the treatment of paroxysmal auricular tachycardia. The dose of quinidine is that as described under the treatment of ventricular tachycardia. If the digitalis is ineffective in stopping the flutter, quinidine may be tried alone. Generally speaking, quinidine is effective in only about twenty to thirty per cent of the cases.

Paroxysmal auricular fibrillation may produce symptoms that may demand a hurried visit from the physician. This condition may be seen in the normal heart but it is more often seen in association with rheumatic heart disease, thyrotoxicosis and hypertensive and arteriosclerotic heart disease. Symptoms are usually those of a rapid ectopic rhythm plus the added possibility of heart failure and shock depending upon the underlying condition. The ventricular rate in an uncontrolled paroxysmal auricular fibrillation usually ranges between 110 and 150 beats per minute and occasionally may go as high as 200 beats per minute. The auricular rate is probably around 600 beats per minute. On auscultation there is the characteristic irregular irregularity. There will usually be a marked pulse deficit and a variation in the intensity of the heart sounds. Systolic murmurs present before the onset of fibrillation will continue to be heard but presystolic murmurs will usually disappear and be replaced by a diastolic rumble. The diagnosis may be made on the irregular irregularity clinically and will be confirmed without difficulty by electrocardiogram.

In the treatment of paroxysmal auricular fibrillation, the doctor must always decide whether he wishes to restore a regular sinus rhythm. If the heart is not markedly enlarged and the patient has not gone into heart failure and the onset of the fibrillation is recent, he may wish to convert the heart to a regular sinus rhythm. Under these circumstances, give quinidine sulphate, 6 grains, every two to three hours. If this is not effective after three or four doses, one may increase the dose to 9 grains five times in 24 hours until a regular rhythm or toxicity results. The quinidine sulphate, as previously described, may be given parenterally rather than by mouth if this is desirable. Quinidine must be administered for two to three months after the attack to prevent recurrence. In restoring a regular rhythm in paroxysmal fibrillation, there is danger of

throwing emboli. Under these circumstances anti-coagulant therapy given before the use of the quinidine has been most effective in preventing such complications. For patients who do not respond to quinidine therapy (or where the patient is in heart failure) it is best to use digitalis in the doses as previously described under paroxysmal auricular tachycardia. Intravenous digitalis preparations will rapidly control the ventricular rate so that there will be an elimination of the pulse deficit and the rate will fall to a level of about 70 per minute. For maintenance of digitalization under these circumstances, use either whole leaf digitalis in a dose of 1 to 2 cat units daily; or give digitoxin, 0.2 milligrams daily or Digilanid[8] in a dose of 0.333 milligrams daily. These dosages will of necessity be increased or decreased depending upon the ventricular rate of the patient and the presence or absence of heart failure. The mere presence of a rate of between 60 and 70 beats per minute does *not* mean that the patient is digitalized. This can only be determined by the use of an atropine test or an exercise test. It is important that the patient be digitalized properly if digitalization is necessary at all.

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89 Lincoln Park

DOCTORS GETTING LESS OF CONSUMER'S DOLLAR

In spite of rising costs of medical care, the physician's share of the medical care dollar dropped from 32 cents to 28 cents in the last two decades. In the same period, the hospital's share sky-rocketted from 14 to 23 cents. As a matter of fact, in terms of real value of the dollar, the consumer can actually buy more medical care than he could in 1935. Frank G. Dickinson, director of the A.M.A. Bureau of Medical Economic Research put it this way:

"A typical 1950 factory worker could purchase almost twice as much medical care with a week's salary as he could have during 1935. Only 53 per cent of a week's wages in 1950 was necessary to purchase the same physician's services as a whole week's pay in 1935.

"The average weekly earnings of production workers in manufacturing industries in 1950 were $59, as compared with $22 during 1935, according to the U. S. Department of Labor. Using 1935 as the base period of 100, the earning index was 265 in 1950. The index of physicians' fees stood at 140 in 1950; 140 equals 53 per cent of 265.

"The amount of services rendered by the average physician was one-third to one-half times greater in 1950 than during 1935. This was made possible through introduction of new drugs, improved transportation, the increasing proportion of patients seen in the hospital and office, and increases in efficiency.

"On the whole, these price indexes indicate that the American people in 1950 were receiving relatively more medical care for their money than they were in 1935.

"But the great improvements in the quality of medical care, which have made a given amount of services so much more effective today, can never be measured by indexes.

"Such tremendous strides in our health progress as the sharp reduction in the number of maternal deaths per 1000 live births from about five in 1935 to less than one in 1950 and the jump in life expectancy at birth from 59.5 years in 1930 to more than 68 years in 1950 are not measured by indexes of the quantity of medical care."

8. Sandoz Pharmaceuticals tradename for a combination of crystalline lanatosides.

BUTAZOLIDIN† IN RHEUMATOID DISORDERS*

A PRELIMINARY REPORT

CHARLES H. SMITH, M.D., Glen Ridge, N. J., and
HAROLD G. KUNZ, M.D., Montclair, N. J.

Butazolidin† is a totally new compound which appears to hold exceptional promise in the treatment of rheumatoid arthritis and allied disorders. Chemically it is 3,5-dioxo-1,2-diphenyl-4-n-butyl-pyrazolidin, a compound entirely unrelated to the steroid hormones. It is also known by the generic designation, phenylbutazone. In pure state, Butazolidin† is a white or slightly yellow crystalline powder of somewhat bitter taste. It is insoluble in water but may be dissolved in alkalis, in ethyl alcohol and other organic solvents.

Butazolidin† was first synthesized in the laboratories of J. R. Geigy, S. A., Basle, Switzerland, in 1948. Prior to the discovery of its distinctive pharmacologic characteristics, it was noted that the compound served as an excellent solubilizing agent for otherwise insoluble dimethylaminoantipyrin. On this account, it was first commercially introduced in Europe in combination with this drug under the name of Irgapyrin. This preparation, consisting of equal parts of Butazolidin and dimethylaminoantipyrin, was issued in ampoule form for intramuscular administration. Its introduction was rapidly followed by a number of clinical reports[1] commenting favorably upon its value in the treatment of rheumatism and associated disorders. In the United States, an identical preparation under the name of Butapyrin was made available to investigators both for intramuscular use and for oral administration. Quickly, however, interest became centered on the Butazolidin† component alone. Accordingly, the manufacturers have for some time been making available for investigation this new synthetic compound alone in the form of tablets, each tablet containing 200 milligrams of active principle. Preliminary reports[2] are now beginning to make their appearance.

DOSAGE

The average effective dosage of Butazolidin† is 600 to 800 milligrams daily taken in divided amounts. In most instances, this dosage will provide satisfactory therapeutic effect. However, in the absence of symptoms of intolerance, the dose may be cautiously increased if therapeutic benefit is not achieved. Once improvement has been obtained on this higher dosage, a gradual downward adjustment should be made to the minimal level required for maintenance. Some patients are well maintained on a dosage as low as 100 milligrams a day.

To minimize gastric irritation, Butazolidin† should always be taken immediately before or after food or with a full glass of milk. The administration of an antacid sometimes proves helpful in overcoming "dyspeptic" symptoms induced by the drug.

DURATION OF TREATMENT

The action of Butazolidin† is usually manifested by the third or fourth day of treatment. It is seldom necessary, therefore, to continue trial therapy with Butazolidin† beyond a week in the absence of a favorable result.

In the treatment of relatively transient conditions such as tendinitis, capsulitis and bursitis, Butazolidin† may be discontinued a few days after symptoms have been completely relieved. In the event of relapse, subsequent attacks are usually as responsive to treatment as the first, and therapy may be conducted on similar lines.

In the treatment of the more chronic disorders, Butazolidin† may be continued indefinitely in the minimal dosage required to keep the patient comfortable and free from acute exacerbations. Such maintenance dosage is generally of the order of 600 milligrams daily, but occasionally this may be reduced to 200, or even 100 milligrams a day.

RHEUMATOID ARTHRITIS

The present series consisted of sixteen cases of rheumatoid arthritis. Diagnosis was confirmed by x-ray or by the typical clinical picture of pain, swelling and deformity, with a long pre-existing history. All patients showed a marked and prompt relief of pain usually

*From the Departments of Medicine and Orthopedic Surgery, Mountainside Hospital, Montclair, N. J.
†Material for this study was supplied by Geigy Pharmaceuticals, 220 Church Street, New York 13, N. Y.

within five days. There was a marked reduction of swelling in *all* cases within the following week or ten days; together with an increase or mobility in the affected joints. Those with marked deformity showed no improvement in the deformity *per se,* but all showed increased mobility.

Sedimentation rate tended to rise during the early stages of treatment. In some cases, the sedimentation rate nearly doubled before showing a decrease. The general trend of all sedimentation rates was upward. There were a few patients, however, in whom the initial sedimentation rate was low, and in these, the trend was toward normal. None of the patients reached a normal rate within the first few months of treatment. In no case was the clinical response in any way related to the changes in the sedimentation rate. In spite of continued elevation, the clinical response was good.

Because of the possibility of liver damage, thymol turbidity tests were done on several patients. There was no change in the albumin-globulin ratio, nor was there any elevation of the thymol turbidity above the normal. It would thus appear that the elevation of the sedimentation rate was, in no way, dependent on liver damage. Repeated urinalyses in all patients under treatment showed no evidence of kidney damage. In no case was there evidence of agranulocytosis. There were no changes in the white count which could be attributed to the use of the drug.

RESULTS

There was at least 75 per cent improvement in all patients with respect to decrease of pain, swelling of joints, and increased mobility. Those patients who were kept on the drug maintained their improvement as long as the drug was administered. Discontinuation of the drug brought on a complete return of the symptoms within a period of time varying from one to four weeks. Return to medication produced the same dramatic relief of symptoms as the initial therapy.

In several instances, it was necessary to discontinue medication because of side reactions. In one case, the patient was taking 600 milligrams of Butazolidin† per day. She developed a seborrheic dermatitis. After discontinuing the drug for two weeks, the rash had entirely disappeared. This patient was subsequently able to return to medication at a reduced dosage of 400 milligrams a day, and after six weeks had no return of the dermatitis. A second patient was placed on 600 milligrams per day and had the usual relief of pain and stiffness of the joints, but developed a macular dermatitis within two weeks, and was forced to discontinue the drug.

Two patients developed nausea and vomiting on 800 milligrams a day. It was necessary to discontinue the drug in one of them since neither the administration of the drug with food nor the use of antacids controlled the symptoms. She refused to continue even at reduced dosage. The other patient continued therapy with the aid of antacid with no further distress.

Hypertrophic arthritis may, in some instances, be a contraindication to the use of the drug where it exists in conjunction with rheumatoid arthritis. One patient with severely deformed and stiff hands obtained prompt relief on the drug, but was forced to discontinue it because of steadily increasing pain and disability in his knees which showed involvement with a hypertrophic type of arthritis. This patient decided he would rather walk than use his hands.

Several patients not included in this series who had either traumatic or osteoarthritis of major joints were given the drug. Results were disappointing and, in several instances, there was actual increase in disability due to increase in pain.

Average effective dosage was found to be 600 to 800 milligrams per day in divided doses. In most instances, this provided satisfactory therapeutic effect. However, in the absence of symptoms of intolerance, the dose was cautiously increased in several patients. The dose in one instance was increased to 1200 milligrams a day at which level relief was obtained. This dosage was given to a patient who had previous therapy with cortisone. The cortisone had been discontinued because of the development of a marked hypertension and a Cushing's syndrome. She received immed-

iate relief of her arthritic symptoms on the institution of therapy with Butazolidin.†

In another instance, cortisone was discontinued after a year of therapy because of increase of hypertension and development of visual disturbances. This patient had been on oral maintenance dosage of cortisone and always had some pain in his hands. When changed to Butazolidin,† he obtained complete relief from pain in the hands and maintained mobility of all joints despite severe deformity. Sufficient time has not elapsed since the transfer to Butazolidin† to determine whether there is any shortening of the time necessary for clearance of the cortisone side effects.

BURSITIS AND CAPSULITIS

An additional series of twelve unselected patients was place on Butazolidin† to evaluate its action in capsulitis, bursitis and tendinitis involving joints, independent of rheumatoid arthritis. Of the twelve patients, ten presented the clinical picture of peritendinitis of the shoulder. Seven were patients with chronic pain, limitation of motion, and atrophy of the muscles of the shoulder girdle. Duration of complaints varied from four months to one year. Of these seven patients, six reported rapid and complete relief of pain. Motion was improved in most of them, but due to atrophy there was residual restriction of motion, which required varied periods of active exercise to overcome. These patients were not only willing, but able to indulge in vigorous active exercise after one or two weeks of medication. In one case, the initial daily dose of 600 milligrams had to be doubled before relief of pain was obtained. One patient in this group failed to obtain relief of any sort during the first three weeks of therapy on a 600 milligram per day dose. There was no opportunity to increase the dosage in this patient, and the result is considered a failure for purposes of this report.

Two cases of acute bursitis of the shoulder involved the subdeltoid bursa, with calcification in the supraspinatus tendon and the bursa. These patients were seen within twenty-four hours of onset of acute symptoms. Both obtained almost complete relief of pain within forty-eight hours. They were continued on the medication for ten days, with complete obliteration of pain and restoration of motion. One additional patient had an acute capsulitis of the shoulder, due to hemorrhage into the joint following a comminuted fracture of the head of the humerus. She obtained almost complete relief of shoulder pain within the first week of medication and was continued on medication for three weeks, during which time the shoulder was rapidly mobilized to prevent the usual stiffness following a fracture. This patient was the typical elderly female who so commonly breaks the head of the humerus in a fall. Her progress in mobilizing the shoulder was much faster than that noted in the average patient with this condition.

EPICONDYLITIS

Two patients were seen with epicondylitis of the elbow, involving the flexor tendon attachment and the radiohumeral bursa. One was seen in an initial acute attack with limitation of extension, pronation of the elbow, and limitation of the grasping motions of the hand. He obtained complete relief within ten days, with restoration of all motion. The second patient had had tenderness over the epicondyle and pain on grasping or lifting for a period of six months. Within two weeks there was marked improvement in the function of the elbow and hand, and local tenderness subsided almost entirely.

This condition ordinarly is very resistant to x-ray therapy, local injection, manipulation or other therapies. The rather remarkable results in these two cases warrants further investigation of the use of the drug for this condition.

SUMMARY

Sixteen cases of rheumatoid arthritis and twelve cases of bursitis, capsulitis and tendinitis, were treated experimentally with Butazolidin† as the sole form of therapy. The drug was found to be subjectively and objectively effective in *all* cases of rheumatoid arthritis although clinical improvement was not reflected in fall of sedimentation rate. Two patients were forced to discontinue the drug because

of nausea, vomiting, and exaggeration of pain in joints affected with the hypertrophic type of arthritis.

Clinically there was a minimum response of 75 per cent relief of pain and swelling. There was increased mobility of the joints proportionate to the decrease in pain. Two patients who were no longer able to continue the use of cortisone because of the development of a Cushing's syndrome and hypertension were placed on Butazolidin† therapy. Both continued to be free of pain and there was a definite remission in the Cushing's syndrome. This remission was probably no more rapid than would follow simple discontinuation of cortisone. It is not to be presumed that the Butazolidin† hastened the regression of the Cushing's syndrome.

Both acute and chronic capsulitis and bursitis of the shoulder respond very rapidly to Butazolidin† therapy. The response was possibly more marked in the acute cases. There was only one patient with capsulitis of the shoulder who did not respond, and it is felt that the dosage in that case was too low. Two patients with epicondylitis of the elbow responded promptly to the medication. This use of the drug should be investigated further, since the condition is usually resistant to the present available forms of therapy.

Citations appear in the authors' reprints

264 Ridgewood Avenue, Glen Ridge
64 Hawthorne Place, Montclair

RECOVERY AFTER 25 MINUTE HEART CESSATION

The complete recovery of a man whose heart stopped beating for 25 minutes was reported in the December 1 (1951) issue of the *Journal of the American Medical Association*. The patient, 63, was undergoing surgery when his heart stopped beating. Life was maintained by massaging the heart, injecting heart stimulants and applying artificial respiration.

Adequate flow of blood to the brain and heart was maintained by manual closing of the aorta beyond the point of exit of the left subclavian artery while the massaging was performed. The closing of this part of the aorta, stopped the flow of blood to the lower portion of the body and forced it to the upper section and brain. In heart stoppage cases, the flow of blood to the brain is of utmost importance in order to prevent damage to the brain should the patient recover otherwise.

"The maintenance of massage of an adequate rate of around 50 to 60 contractions per minute was so fatiguing that the surgeon and the first assistant alternated for periods of five minutes each."

The patient recovered completely and was discharged 11 days after the operation. Subsequent examinations have shown him to be as mentally sound and alert as at the time of the operation.

Because of the success of the procedure of closing part of the aorta during the massaging of the heart, Carter suggested it be used in all such heart stoppage cases.

PROCTALGIA FUGAX

Proctalgia fugax is a symptom complex probably caused by spasm of the internal anal sphincter and the anorectal ring. It is characterized by severe paroxysmal attacks of local perianal pain, and may be associated with precordial pressure, pallor, profuse perspiration and transient fainting. Its pathogenesis and treatment have been described by Drs. J. D. Karras and G. Angelo in the November 1951 *American Journal of Surgery*. Thus far 125 cases have been reported; its incidence appears to be greatest in males between the ages of 30 and 50 and it is relatively common among physicians. The pain is "spastic" in nature, and is relieved by antispasmodic drugs, local pressure, or heat. Sublingual nitroglycerine at the time of onset frequently aborts an attack.

SEQUELAE OF HEAD INJURY *

Samuel Brock, M.D., New York, N. Y.

Cerebral concussion, it is generally agreed, is a state almost but not entirely peculiar to the brain, that it is a result of traumatic effects *generally* distributed throughout the brain, and that it is a basal condition for most of the acute traumatic syndromes affecting the brain. Easily the most arresting feature of this general concussive brain injury is the change in the patient's state of consciousness. This has led physicians for many years to use unconsciousness (or similar phenomena) as the essential yardstick by which to measure the degree of cerebral concussion. It is an imperfect instrument, but it is the best we have: it must be checked against other factors. All students of consciousness have been intrigued by the changes in consciousness induced by head (brain) injury, and while there are serious gaps in our knowledge, it may be stated (1) that general brain injury seems to be able to affect the state of consciousness quite readily, (2) that this seems to be due to the extreme sensitivity of a nervous area which has the ability to arouse the brain to general awareness, (3) this area apparently lies deeply in the upper brain stem and diencephalon. Some of the evidence for the above statements may be found in the recent work of Magoun,[1] Penfield,[2] Geoffrey Jefferson and R. Johnson,[3] and Russell Brain.[4] A number of other conditions have a "value" equivalent to unconsciousness. I refer to dazed states, states of depersonalization (which have been described especially in pugilists), states of apathy and fugue states with amnesia and even states of deliria,—to name the most common. What we do not understand is the *variability* of the reaction of individuals in regard to concussive injury, when it comes to their own particular conscious reaction. A certain type of blow will knock one man "groggy" for a few minutes, while the same blow will render another man of the same age unconscious for hours. Nor do we know why children can withstand and recover sometimes amazingly from severe cerebral concussion, while older people fail to recover fully from mild concussion. We may suspect that it may be related to the state of the cerebral blood vessels, but this is just a guess.

The term "cerebral concussion" unfortunately has not always meant the same thing to different medical observers. There are those who would restrict its use to a reversible (and therefore recoverable) state, which of course would have no sequelae. Most students of the subject, however, believe that this is only one variety of the condition. Elsewhere for descriptive purposes I have referred to the following types of concussion: (1) mild or transient, (2) prolonged, and (3) fatal,—a naively simple division which does no more than to say that you may die of the condition, suffer a rather long siege of illness, or have done with it in a very short time.

All this is a prelude to what we all know as the common *postconcussion state*. As with all familiar phenomena, we are likely to become careless in applying criteria covering this syndrome and we may put more into it than belongs there, with the result that the term again does not mean the same thing to all who use it.

Let us begin with the *headache* following cerebral concussion. Many types of headache are complained of following concussive injury. One of the commonest and most certainly truly postconcussive presents the following qualities: it is a dull throbbing or pounding pain, subject to sharper jabs at times, sometimes but not always worse at the site of impact, which may be felt in any part of the head; it is made better by quiet rest in the recumbent position, and is worse on bending the head forward or on straining (as occurs in coughing) and worse, sometimes, in humid, rainy weather. Alcohol,

* Read at the Second Annual Institute in Psychiatry and Neurology sponsored by the Veterans Administration Hospital, Lyons, N. J., and the New Jersey Neuropsychiatric Association, April 16, 1952. Dr. Brock is Professor of Neurology, College of Medicine, New York University.

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3. Jefferson, G., and Johnson, R.: Folia psychiat. neurol. et neurochir. (Netherlands), 53:306 (1950).
4. Brain, W. R.: *Brain*, 73:465 (1950).

extremes of heat, excitement and emotional upset aggravate the headache. Analysis of these factors suggests that we are dealing with a *vascular* headache, though the exact pathology is unknown. Not infrequently this headache is the sole postconcussion sequel and the most stubborn. Treatment is unsatisfactory. Patients, as well as physicians, have found that such simple remedies as aspirin and Empirin† are as temporarily effective as any others. We are all looking for a specific but have not found it. Avoidance of the factors which increase the headache is advisable, but can hardly be called "treatment". The therapy is made more difficult, too, by the frequent association of this type of headache with postconcussive dizziness, both occurring at the same time, or each sometimes occurring alone. Luckily, this true type of postconcussion headache tends to improve with time, but there are exceptions, especially in older persons.

There is also a type of back-of-the-head-and-neck ache, which the patient will often describe as a "tight, pulling" ache. This is a muscle tension pain, symptomatic of anxiety and is a secondary neurotic manifestation. Its treatment centers about the proper handling of the patient's neurotic personality reaction. Now and again, sharp upper neck and occipital pain is due to disease or injury of the uppermost cervical vertebrae. Pain on neck movement, relief upon holding the neck immobile, and x-ray studies (including myelography at times) point to the source of this type of pain. I now refer to "neurotic headache", noting that the various other head symptoms to which the neurotic so often refers are also encountered here, such as feelings of "heaviness" on the head, the tightness about the head, a "hollowness" within the head, peculiar burning sensations or feelings of formication in the scalp.

A few so-called "postconcussion headaches" turn out to be really instances of migraine accentuated by the accident. Here treatment, medicinal as well as psychological, requires a different orientation. Another type of *head pain* lost in the general shuffle may be mentioned; that is an occasional local sharp stabbing pain at the site of impact of the blow. Examination discloses a very tender focal area and injection of Novocain‡ causes the pain to disappear. Here we are dealing with a scalp nerve involvement, which requires local block. Involvement of the supra-orbital nerve in this type of neuralgia is not uncommon. Occasionally a patient complains about a similar condition in nerve filaments caught in a scalp scar. Less common than all of these are individuals who continue to describe sharp lancinating pains at the site of the trauma long after all external local pathology has subsided. These patients should first be treated along the lines of local nervous ("neuritic") involvement, as above mentioned. However, Penfield and Norcross[5] stated that some types of persistent localized headache may be due to traumatic adhesions between dura and arachnoid, resulting from a small subdural hemorrhage. These authors believe that the insufflation of air (as in pneumoencephalography) helps this type of headache. In using this treatment, the patient is kept lying on his side with the head held elevated and injured side up, and maintained in this position for about two days. What makes headache following head trauma confusing is the fact that one may be facing more than one of these types of headache;—then the disentangling process may be far from simple. *Slowly* developing headache appearing *after* a free period should raise the question of subdural hematoma or other intracranial condition. Other nontraumatic types of headache also appear or are added to confuse the issue.

Let us next turn to the question of *dizziness*. Several types may be discerned: *true postconcussional* dizziness seems to be brought about by the same mechanisms causing the first headache described above: often the headache and dizziness are concurrent and similarly influenced. However, true postconcussional dizziness is usually of much briefer duration and rarely lasts as long as the accompanying headache. It is much influenced by changes in posture, occurring particularly as the patient gets up in the morning or bends over. It is worse

† Empirin is a trade-name registered by Burroughs, Wellcome and Company, for a compound containing caffeine, acetophenetidin and acetylsalicylic acid.

‡ Novocain is the trade-name registered by Winthrop-Stearns, Inc., for their brand of procaine hydrochloride.

5. Penfield, W., and Norcross, N. C.: Archives of Neurology and Psychiatry, 36:75 (1936).

when the head is turned rapidly from side to side, but occurs at times independently of head movements. It rapidly subsides when the patient sits down; ordinarily, it is unaccompanied by nausea, or fainting or "blackouts". When the latter symptoms occur, neurotic factors are dominant. The treatment of this type of dizziness is unsatisfactory and we have no specific. Dramamine§ has been used with indifferent results. Fortunately, this type of dizziness tends to clear up even before the type of headache which it often accompanies. Only rather rarely does it persist as a single postconcussion effect.

Now and again one meets with true *labyrinthine dizziness* either of purely concussive origin or due to inner ear disease. This type of dizziness is apt to be solely dependent on head movement. It is likely to be more violent than the type above described, and may be associated with other evidences of ear disease in the history and on examination. Sometimes the problem of aggravation of an antecedent inner ear disease is raised. Treatment of this type of dizziness is in the province of the otologist.

Neurotic dizziness is a much commoner symptom. It develops in otherwise neurotic types. The dizziness is of much longer duration, though often enough not nearly as disabling as the description of the condition would have led one to suppose. On the other hand, with this dizziness, we often meet the "blackout" in which the patient passes out or faints, never with convulsive movements, or with involuntary incontinence (urinary or fecal), never with an epileptic cry or biting of tongue, and never with an epileptic electro-encephalographic pattern. This is not to say that certain "blackouts" may not be of true epileptiform character with signs pointing indubitably to that condition. This neurotic type of dizziness is likely to be experienced especially when the patient is on a height, though I do not believe that this quality alone distinguishes it from the true postconcussion dizziness.

Noises in the head and tinnitus are frequent complaints. The basic cause of these symptoms is not clearly established. Fortunately, they tend to disappear in time.

The milder, nonpsychotic mental symptoms, include undue fatigability (physical and mental), inability to concentrate with faulty retention and limited attention span, irritability, increased noise (and light) sensitivity, anxiety and "jitteriness". While these symptoms have been described in those without compensation and/or litigational problems or other worries, there is no doubt that such conditions act as major aggravating factors, both in terms of precipitating the symptoms and in keeping them active. Are we dealing here with a neurotic personality reaction pure and simple? Or does the altered "character" stem from organic changes incidental to diffuse brain injury? Kozol[6] has noted that some of these so-called "post-traumatic neurotics" do not exhibit pretraumatic neurotic personality patterns; yet we have no real study of a group of individuals before and after head injury and are in no position to rule out dormant pretraumatic neurotic traits. Severe and persistent "neurotic" symptoms seem to flourish on the soil provided by various emotional and anxiety producing substrates. The answer may have been given by Alexandra Adler.[7] She pointed out that the pretraumatic factors, which were followed by a higher incidence of post-traumatic mental symptoms, were: the older (over 50) age group; Latin or Slavic stock: work in dangerous occupations; vocational conflicts and difficulties; pending litigation; coexistence of other diseases; financial worries: pre-existing anxiety, hypochondriasis and depression. Such factors point heavily in favor of the purely neurotic cause and motivation of these symptoms.

Obviously, then, we have a body of data which also points the way in treatment. To start with, one must remove as many of the neurosis-provoking factors as possible. This implies elimination of all compensation and/or litigation by settlement or otherwise; change of occupation to less hazardous work; composing all employer-employee differences; elimination of all sources of domestic conflict; help along financial lines when possible; adequate treat-

§ Dramamine is dimenhydrinate. The word "Dramamine" is a trade-name registered by G. D. Searle and Company.

6. Kozol, H. L.: Archives of Neurology and Psychiatry, 53:358 (1945).

7. Adler, Alexandra: Archives of Neurology and Psychiatry, 53:34 (1945).

ment of other diseased conditions; and the use of some form of work when possible as a therapeutic agent. This program should be accomplished in association with a simple psychotherapy in which sympathetic but firm reassurance are the keystones, buttressed by appropriate sedative and other medication. Alone, the purely "medical program" is useless. These injunctions are not new, but one must keep on reaffirming the old truths because millions of dollars are wasted in this country by various nostrum therapies in assembly-line fashion, in vain attempts to cure these unfortunate individuals without correcting basic faults. When at long last these are remedied, then finally and after much waste of time, money and needless suffering, the individual may be returned to industry. I do not mean to indict any one group as responsible for these conditions. We are all to blame so long as doctor and lawyer, legislator and referee, employer and employee fail to get together to correct a socio-economic rift.

There has been much discussion of the problem of malingering versus conversion hysteria. After long experience, I have been forced to conclude that too many physicians have very unclear and, at times, biased views. For some, all is malingering; for others, all is hysteria. Much harm flows from this confusion. Let us accept some basic principles and proceed therefrom: malingering is fraud, deceitfully carried out on a conscious level for some kind of gain, whether the simulator is pretending disease or hiding illness. The malingerer does not exhibit his wares when unobserved, since it is too much of a job to keep up the act hour after hour. It is too inconvenient. Since his trickery is a device, one must employ ruses to detect the fraud. This is sometimes easy. Moving picture films often give the lie to the faker who has sworn that he has been unable to do this or that. In longstanding cases, one may have to be resourceful. Here is an instance of how planning and teamwork may uncover deception. For some time following a minor injury to the head, a young woman shuffled stiffly along on her right lower limb, which was held extended and somewhat abducted, knee unbent. Appraised of the problem, I rearranged the approach to my examining room so that she would have to pass through a kind of narrow strait of perhaps four or five feet made by some chairs. I pretended to be writing and not watching. She hobbled to the entrance of the narrow passage, then walked normally for about 4 or 5 steps and, coming out, resumed her abnormal gait. This was malingering in pure culture, suspended for a very brief interval when it became too inconvenient to maintain the deception.

Hysteria operates at subconscious levels, and produces a large variety of paralytic, spastic, and dyskinetic syndromes. While these clinical pictures may vary, they are not present one moment and absent the next. The hysterical fit, in fact, lasts much longer than the real epileptic seizure. Moreover, the convenience of the patient and the scrutiny of the examiner do not determine the presence or absence of the condition. A neurosis is always an inconvenience and always an illness. Hysteria and fraud may co-exist and the examiner may have to spend considerable time trying to apportion the parts played by each. And also each may appear in pure culture. In this connection, I would like to stress a frequently forgotten point. Some long-established "pedigreed neurotics" make *fraudulent use* of their neurosis in attributing it falsely to head injury and/or in exaggerating its disabling features. In these cases, detailed history and careful observation should put the neurosis in its proper place.

Time permits only a cursory discussion concerning the therapeutic approach to conversion hysteria. Sodium Amytal¶ narcosis (with "analysis and synthesis" and hypnosis) plays its part, so does the modified application of psychoanalytic technics and always the removal of socio-economic and interpersonal inciting factors.

It is interesting and, I think, significant, to note the relative rarity of obsessive-compulsive features in the head (brain) injured, except in those previously afflicted. In the neurotic with hypochondriacal tendencies, head injury

¶ Amytal is the Eli Lilly and Company's trade-name for amobarbital.

may simply provide a new frame of reference displacing the cardiac area or the gastro-intestinal tract as the sounding board for emotion. The loss or blunting of consciousness in head injury prevents the development of the "terror neurosis" seen in those who have lived through harrowing hours on sinking ships, life rafts, or in earthquake stricken areas. Victims of such holocausts reveal a clinical picture of tense anxiety and panic, fearful apprehension, and recurrent nightmares of the catastrophic happenings. Tremor, tachycardia, vasomotor and other autonomic nervous disturbances accompany the above symptoms.

Epilepsy in one form or another has followed head injury, especially after "open" head injuries. As a sequel of pure concussion, it is rare. It was not observed even once by Elvidge[8] in his series of 362 cases. As one proceeds "inward" with skull fracture, contusion and laceration of the brain, foreign body, et cetera, the incidence of epilepsy as a sequel rises to an incidence of from 27 to 38 per cent. Both grand and petit mal may appear anywhere from one to ten years after the injury. The pattern of these post-traumatic seizures may be indistinguishable from the pattern of idiopathic epilepsy. There is an important corollary to this. After an *open* head injury, it is wise to treat the patient with an anti-convulsive regime for about two years. This is especially desirable if the electroencephalogram has shown focal change or an epileptic pattern, or if epilepsy is "in the family tree". Concussion may aggravate pretraumatic convulsive seizures though I believe this to be only temporary. In an "open" head injury, the aggravation may be permanent.

A simple linear fracture of the skull is a silent witness to the fact that a blow of some force was received; but it may have its beneficient aspect in that the force of the blow may have been taken up by bone rather than by brain; thus that the victim's brain may have been spared greater injury. Skull x-ray may reveal information of a varied character concerning other types of fracture, calcification, pineal shifts, et cetera. A single electroencephalogram in head (brain) injury is of restricted value; to be of real help it should be repeated in a series of observations. Serial electroencephalography has been carried out by Dawson, Webster and Gurdjian[9] in 45 cases. Sixteen of these patients died 3 days to 6 weeks after injury. Their conclusions were:

"Soon after injury, the *basic rhythm* in the electroencephalogram may be normal even though the patient is fatally injured. During the first 24 hours after injury, subdural hematomas did not register any clear focal abnormality in the electroencephalogram; but from the second or third day on, they always cause a suppression over the lesion. *Focal delta activity* indicated the site of the greatest injury or of a mass lesion in only about half the cases. Three or four cases with acute subdural hematomas showed focal delta activity on the side opposite to the hematoma. In one patient, only a transient delta focus was noted over the lesion which proved to be an intracerebral clot at autopsy. Among patients with uncomplicated head injury and a prolonged recovery period, the basic activity initially was usually only slightly slowed, but showed progressive slowing and disorganization even while the patient's clinical condition improved. (This may be due to cerebral edema.) An initial basic rhythm ranging from 4 to 6 per second and appearing within 48 hours after injury was an extremely grave sign. Six such patients succumbed. If slowing of this degree was delayed until after the second post-injury day, the patient usually survived. Early *complete suppression of all activity* was also a grave sign. This was seen within 30 hours of injury in three patients and the suppression persisted until they died 2 to 4 days after injury."

Denis Williams[10] has paid particular attention to the electroencephalogram in head injury, and he makes the following observations:

"When a closed head injury occurs and concussion results, there is (at the time of the concussion) complete cessation of spontaneous electrical rhythmic activity in the cerebral cortex. Records are flat during the period of bradycardia and respiratory spasm and while reflex paralysis persists. After a few seconds or minutes some activity returns. These consist of very slow waves of low voltage and from all areas rhythmic 1 and 2 per second waves can be recorded. The duration of these generalized slow waves depends on the severity of the injury and the rate of recovery. There is a close relation between their disappearance and clinical resolution. The frequency of the waves increases, their voltage falls and they finally become intermittent. At the same time, the alpha waves make their appearance and slowly increase in voltage. This process may take weeks or months, or in a simple injury with

8. Elvidge, A. R.: Injuries of the Brain and Spinal Cord and Their Coverings (Edited by S. Brock). Ed. 3. The Williams & Wilkins Co., Baltimore. Chapter 11. (1949).
9. Dawson, R. E., Webster, J. E., and Gurdjian, E. S.: Transactions of the American Neurological Association, The William Byrd Press, Inc., Richmond, Va. Page 158 (1951).
10. Williams, D.: Modern Trends in Neurology. (Edited by A. Feiling). Paul B. Hoeber, New York. Chapter 19 (1951).

momentary amnesia may be complete in a few hours. It is usual to find some residual abnormality in the electroencephalogram for a time after clinical recovery appears superficially to be complete. It is during this period of spurious recovery that the patient is liable to return to work and responsibility only to realize that he is unequal to the stress and so to develop the symptoms of a post-traumatic state.

"If the head injury is focal, the same train of events follows, the changes being limited to the site of injury. Residual focal disturbances may persist after resolution of the generalized disorder appears to be complete and, indeed, during the immediate post-traumatic period the focal disturbance may be masked by the general disorder. Whenever the dura has been perforated and particularly when foreign bodies have been driven into the brain, the local abnormality is very severe and consists of absence of the normal rhythms and the presence of very slow waves of a high voltage. Generalized slow waves are only present if the patient is in coma, if concussion has accompanied the injury, or if some other complication, such as high intracranial pressure, is present. If the damaged brain tissue is removed, the local abnormality will in most cases become insignificant and may disappear within a few hours of the operation. It is unusual for a patient to lose sufficient cortical tissue to lead to permanent abolition of the normal frequencies on one side, but this is liable to occur if the injured area includes the site of origin of the alpha rhythm in the parieto-occipital cortex (or) if a subdural hematoma overlies the posterior parietal area. . . . if the hematoma is frontal or temporal, it may not produce any changes in the electroencephalogram or merely low voltage slow waves of the kind seen with mild cortical damage."

The fact that the loss of brain tissue does not produce changes in the electroencephalogram detracts from the value of this procedure in post-traumatic mental states. Moreover, changes in the electroencephalogram may have a non-traumatic etiology. It is fair to infer that a focal dysrhythmia is most likely due to the injury.

The age, the pretraumatic history of the patient, the treatment he has had and is now undergoing, the state of his electrolyte and sugar metabolism, and, in some instances, data relative to oxygen intake will prove necessary in the analysis of the data. Further studies are needed along this line.

One of the most difficult and vexing medicolegal complications of brain injury concerns the question of the *activation or aggravation of non-traumatic diseases* of the brain by head injury. Some physicians believe that almost any kind of head injury can precipitate or aggravate almost any type of brain disease, especially if the brain disease is of unknown etiology. These observers take the following position: we do not know what causes, say, schizophrenia; therefore, how can we deny that a cerebral concussion might precipitate this psychosis? I am out of sympathy with this type of speculation for two reasons: first it *compounds* speculations giving a positive attribute rather than a negative one to an unknown factor; second, and even more important, the proponents of this line of reasoning close their eyes to statistics which fail to support their speculations; namely, thousands of individuals are concussed and very few develop schizophrenia. Thousands of individuals develop schizophrenia with no record or history of prior injury. If there were really any trauma-disease relationship, statistics would show a much greater concordance. What has been said of schizophrenia applies with equal force to multiple sclerosis. On the other hand, with reference to the traumatic precipitation of *general paresis,* enough evidence has accrued to show that there may be such a relationship. When neurosyphilis was commoner than it is today, writer after writer noted this fact. Happily, general paresis is becoming so rare that the problem is not a lively one any more.

The question of the traumatic aggravation of parkinsonism is important. Parkinsonism may be a part of the "punch-drunk" state, the result of many repeated concussional effects; but this is a comparatively rare occurrence. Usually we are asked to consider the aggravation of a chronic encephalitic or a degenerative parkinsonian by head injury. If the concussion were quite severe, such aggravation might well occur; but I cannot accept the notion that a mild transient concussion can produce or modify the deep lying pathology underlying the parkinsonian state. I do not recall any cases of this sort, the course of which *definitely* established a direct causal relationship between injury and paralysis agitans.

Some physicians are sure that a *single* head injury can influence the rate of growth of tumor cells, and thus accelerate a brain tumor.

Such a belief, though speculative, is worthy of careful consideration in view of the fact that injury and neoplastic formation have been associated in growths in various parts of the body. The least one can ask, however, is that there be careful correlation between the injury and the growth in point of time relationship and anatomic propinquity. Thus, if a man sustains, say, a fracture of the right parietal region and subsequently (say 10 years later) evidence of a meningioma at this site is forthcoming, then one has to admit that such a slow growing neoplasm might be related to the trauma. If 10 years elapse and the patient is suddenly found to have a rapidly growing and quickly fatal glioblastoma, it is much more difficult for me to see any relationship. The time sequence pattern does not fit. At times, the anatomic site of the lesion is too far removed from the site of the traumatic impact and thus the link of causation is broken. Again we must keep in mind the statistical facts: in the case of the more rapidly growing neoplasms, trauma seldom plays a part, and in the overwhelming majority of the brain-injured, cerebral tumors never develop. One must keep an open mind on the subject and avoid an unscientific bias.

115 East 61st Street

STANDARD NOMENCLATURE—NEW EDITION

The American Medical Association has now made available to hospitals the new Fourth Edition of Standard Nomenclature of Diseases and Operations.* Since its inception under auspices of the New York Academy of Medicine, and the First National Conference on Medical Nomenclature in 1928, and the subsequent transfer of responsibility for its periodic revision to the American Medical Association in 1937, the *Standard Nomenclature* has grown rapidly to become the most widely accepted system for the diagnostic coding of hospital records for more than 70 per cent of our hospitals. The dual topographic-etiologic coding has proved its flexibility both through ease of simplification for the small hospital, and in expansibility for the large teaching institution.

Because of wide acceptance of this coding system, and the fact that hospital record systems using *Standard* must make the changes provided for in each revision, the editors have cautiously avoided changes that are not absolutely necessary. Nevertheless, rapidly expanding scientific knowledge has required some changes in several sections of the book. These have included a complete revision of the psychobiologic section to bring it into accord with terminology of the American Psychiatric Association, a new presentation of diseases of the blood and lymphatic section to accord with current thought in this field, and an extensive revision of the section on tumors. Changes in the nomenclature and coding of tumors come about as a result of the deliberations of the "Standard" Committee on Oncology with committees of related organizations.

The Fourth Edition of *Standard* now includes an appendix cross reference of *Standard* code numbers to code numbers of the *International Statistical Classification of Diseases, Injuries and Causes of Death.* The *International* code numbers have also been included parenthetically in the nomenclature section of the book. This will simplify the work of hospital staff officials who wish to participate in large scale state, nation, or world statistical studies of disease incidence. Unfortunately, for purposes of hospital recording, the systems are not interchangeable. The *Standard* system, as a clinical instrument, is necessary for the proper separation of individual differences in diseases for recording and research purposes, whereas the *International* system applies mainly to much broader disease groupings for statistical purposes. Thus, one code number in the *International* list may be used to represent twenty or more conditions classified and coded separately in the *Standard Nomenclature.*

The *International* list is now accepted on a world basis for statistical analyses by the countries participating in the World Health Organization. Cross coding to *Standard* is a tremendously detailed and time-consuming work. It is hoped that the combined systems, clinical and statistical will be an appropriate consideration for the World Medical Association for adoption in some early revision.

* Published by the Blakiston Company, Philadelphia.

DIAGNOSIS OF LOW BACK PAIN *

John J. Flanagan, M.D., Newark, N. J.

The low back is probably the site of more disabilities, anomalies, and subjective complaints than any other portion of the body. Backache has been an affliction of mankind throughout the history of the human race. Low back pain, or backache, frequently called lumbago, is a symptom and not a diagnosis. The same is true of sciatica. Therefore, before intelligent treatment can be instituted, an accurate diagnosis must be made.

The following conditions are the most common and chief causes of backache:

1. Congenital anomalies
2. Traumatic injuries
3. Mechanical strains
4. Infections
5. Neoplasms
6. Metabolic and degenerative diseases
7. Nervous system disorders
8. Functional or psychosomatic diseases
9. Disorders and diseases of the internal organs, chiefly the urologic and gynecologic organs.

1. The most common *congenital* defects of the lumbosacral area of the spine are as follows:

Defects of the neural arch, particularly spina bifida, or failure of fusion of the posterior neural arch. Most commonly, the defect is minute and causes no symptoms in my opinion although in medico-legal cases, great claims of disability are made on grounds of traumatic aggravation of this pre-existing congenital anomaly. Where the defect is large, with presenting meningocele, or meningomyelocele, we are indeed presented with a serious problem. Occasionally, we see a case where there is impingement of the spinous process of the fifth lumbar vertebra on the cauda equina through wide defect in the last sacral segment.

Spondylolisthesis, with varying degrees of forward displacement of the body of the affected vertebra, usually the fifth lumbar, and the superimposed spinal column, is an infrequent, but serious disability. It is due to congenital failure of fusion of the laminae and pedicles of the neural arch of the affected vertebra. Its most serious complication is pressure on the adjacent nerve roots and cauda equina requiring strenuous surgical procedure.

Transitional vertebrae, either in the form of sacralization of the fifth lumbar or lumbarization of the first sacral segment, is probably the most common symptomatic congenital defect. This is true where there is unilateral or bilateral false articulation of the abnormal transverse processes with the vertebra below and the sacrum laterally.

So-called *asymmetrical facets* of the lumbosacral articulation, where the plane of the joints varies on either side, is supposed to be a cause of low back pain. However, this is seen roentgenologically in many normal spines and it is not a common factor in low back pain.

2. The most common *traumatic* injury to low back area is acute sprain of the lumbosacral joint, with stretching beyond normal physiologic limits or actual rupture of the supporting ligaments of the lumbosacral joint. This is a painful and disabling injury as the affected ligaments are richly endowed with nerve endings. The lesion is associated with marked spasm of the posterior spinal muscles. Pain begets muscle spasm. The so-called "sacro-iliac sprain" or "subluxation" is practically non-existent, in my opinion, as these two joints are large strongly supported joints and not subjected to anywhere near the stress and strain of the inclined lumbosacral joint with its superimposed weight of the trunk and upper extremities.

Strains of the *posterior spinal muscles,* either unilateral or bilateral, due to stretching of the muscle fibres beyond their physiologic limit with resulting petechial hemorrhage occur occasionally, but this traumatic condition is rare. The true culprit is the supporting ligamentous apparatus of the lumbosacral joint when the supporting low back and abdominal muscles have failed in their function as shock absorbers.

Traumatic myositis of the low back area does occur, but is usually the result of a direct blow, with rupture of the muscle fibres and hemorrhage within the muscle sheathe.

3. The most common cause of *mechanical strain* of the lumbosacral area is poor posture. This maladjustment of body mechanics is readily apparent on examination of the spine, with so-called "sway back", caused by the dorsal round back deformity of exaggerated dorsal kyphosis with marked increase in the lumbar

* Read before the Section on Orthopedic Surgery at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1952.

lordosis and lumbosacral angle. This static strain on the supporting lumbosacral ligaments must, of necessity, produce low back pain because of the abundance of sensory nerve endings in the affected ligaments. Where poor posture, with exaggerated lumbosacral angle, is the cause of the low back symptoms, hyperextension of the spine, in the erect position, will confirm the diagnosis. This is also true in static strain due to obesity.

Occupational strains, various types of curvature of the spine, inequality of leg length, tilting of the pelvis, and, to a lesser degree, static deformities of the feet, will cause low back disability of varying degree.

4. *Infections* causing low back symptoms include rheumatoid arthritis, osteomyelitis, tuberculosis, and, to a lesser degree, the mycotic infections. Low back pain secondary to malaria, undulant fever, and typhus fever is common.

5. *Neoplasms* causing low back disability include primary bone tumors and metastatic lesions. We classify these into benign and malignant tumors. The commonest benign tumors are osteoma, osteochondroma, and hemangioma. The most common malignant tumors are metastatic carcinoma, solitary or multiple myeloma, osteogenic sarcoma, and Hodgkin's disease.

6. *Metastatic and degenerative diseases* include Paget's Disease, gout, osteo-arthritis, osteomalacia, hyperparathyroidism, senile osteoporosis, and Marie Struempell spondylitis.

Herniated or *ruptured disc* is a degenerative disease, although trauma is frequently a definite factor in the inception and onset of this specific syndrome. Degeneration of the intervertebral disc, as Barr† points out, occurs frequently and apparently is an example of the normal aging process in collagen-bearing tissues. In this lesion, the nucleus pulposus ruptures through the annulus fibrosus, posteriorly or postero-laterally, beneath the posterior longitudinal ligament into the spinal canal, causing pressure on the nerve roots at the affected level. The most common levels are the interspaces between the fourth lumbar and the first sacral levels, thus affecting the fifth lumbar and first sacral nerve roots. Since the main components of the sciatic nerve are the first sacral and last two lumbar nerves, pressure on one or more of these nerve roots, intraspinally, produces the typical referred pain along the course of the sciatic nerve. Hence, the most common sign in the syndrome is limitation of straight leg raising, when the sciatic nerve is put on stretch. Other common signs and symptoms are positive jugular compression, limited flexion of the trunk with knees in full extension, localized tenderness over the sacro-sciatic notch, at site of exit of the sciatic nerve from the pelvis on the affected side, hypesthesia of skin surface of the affected dermatome, and diminished or absent ankle jerk.

Where conservative treatment has failed and operative hemilaminectomy is anticipated, pantopaque myelography is an essential diagnostic procedure in localizing the level or levels of the disc pathology. However, this procedure will not reveal the occasional disc located lateral to the dural sleeve.

7. Under organic neurologic system disorders, we have cases of neuritis, radiculitis, meningitis, encephalitis, and arachnoiditis.

8. Under the heading of functional or psychosomatic disorders, we consider hysteria and, of course, malingering.

9. Disorders of the internal organs include gynecologic and urologic conditions; we think of prostatitis, kidney stones, ptosis of the kidney; and under the gynecologic heading, prolapse of the uterus, retroversion, adhesions, tumors, and obstetrical problems. Chief, of course, among these are the cases of low back pain secondary to retroversion of the uterus.

For helping to make a diagnosis, x-rays are of great benefit and we usually, in attempting to find a lesion in the lumbosacral area, request five views of that region: first, a standing lateral view of the lumbosacral joint to get the weight-bearing angle of the lumbosacral joint itself, the angle of function; second, the full antero-posterior view of the sacrum, with the tube tilted cephalad approximately thirty-five degrees so as to get a full view of the sacrum instead of the angle view that we get in an

† Barr, J. S.: Low Back and Sciatic Pain, J. Bone and Joint Surg., 33:633 (July 1951).

antero-posterior film of the pelvis; third, an antero-posterior view of the pelvis; the fourth and fifth views are right and left oblique views of the lumbosacral joint to reveal the articular facets. And then, of course, we may request special views where indicated.

DISCUSSION

H. E. READING: Dr. Flanagan has done well indeed in covering so extensive a subject as low back pain in the limited time allowed.

Retroversion of the uterus has been a much discussed and disputed cause of low back pain in the past. I agree with Dr. Flanagan that sacro-iliac sprain or subluxation is an uncommon condition. I first became aware of an exception to this thought when in 1930 I was asked to examine several patients at the Fifth Avenue Hospital in whom backache persisted following suspension of the uterus. Since that time I have seen a number of female patients with a similar pain syndrome, irrespective of the presence of retroversion of the uterus.

The history in each of these patients is quite similar:— backache, most often localized to the lower back on one side extending to the gluteal and hamstring muscles on that same side. The onset of pain is after the fifth month of pregnancy. Rest in bed during the post-partum period affords relief from pain. Subsequent weight bearing causes the patient to speak of persistent, nagging pain.

Digital examination in each of these patients reveals abnormal mobility of one of the pubic bones at the symphysis. The mechanism is that of an unstable pubis transmitting slight motion and therefore slight instability of the sacro-iliac joint on the affected side. As time progresses a traumatic arthritis slowly develops in the involved sacro-iliac joint.

The theoretical basis for this condition is the production of a hormone in the pregnant woman called "relaxin" which plays a part in the widening of the symphysis pubis after the fifth month of pregnancy. Immediately following delivery, an opposing hormone called "contractin" is supposed to cause rapid contraction of the previously relaxed symphysis.

Where no appreciable contraction of the symphysis pubis occurs instability at this area persists and transmits strain to the sacro-iliac joint.

X-ray confirmation can be determined by antero-posterior views of the pubic bones on each side of the symphysis,—the patient standing on one foot for the first film and then standing on the opposite foot for the second antero-posterior view. These films will reveal which pubic bone appears elevated in relation to the symphysis.

Gout as an underlying contributing factor in backache is much more common than is thought. The absence of an elevated blood uric acid does not rule out gout. Colchicine in adequate dosage helps to confirm or rule out gout as an underlying cause of backache where a metabolic disturbance is suspected.

Some additional information can be gleaned in disc lesion causes if weakness is present in great toe extensor power on the affected side.

173 Roseville Avenue

ARE MASS CANCER SURVEYS EFFECTIVE?

For four years, Johns Hopkins has been studying the effectiveness of mass gastro-intestinal x-rays in detecting malignancy of the gastro-intestinal tract. More than 40,000 persons over 40 years of age have been surveyed. Writing in the January 1952, *American Journal of Roentgenology,* Drs. J. F. Roach, R. D. Sloan and R. H. Morgan summarize the results of the survey as follows:

"The number of persons found to have the disease in its early stages was relatively small, being approximately 1 per 476 examinations, or 0.2 per cent in the series. It was our experience that only a few of these can be persuaded to submit themselves to surgery prior to the development of symptoms. It appears that the general public must receive further education concerning the gastric cancer problem before photofluorography will be successful. Common x-ray procedures are the best means at our disposal for the examination of the stomach. The conventional methods, however, are not easily adaptable to mass survey needs. For that reason photofluorography was given a long trial."

"This method was better for mass surveys because the presence of a fluoroscopist is not required and the examination can be rapidly and easily executed by a technician. The cost of the film is not excessive and its storage offers no real problem. In 9072 of the 10,000 studies, or 90.7 per cent, it was felt that the stomach was visualized sufficiently well to warrant a diagnostic interpretation."

"Out of all the cases studied there were only 27 with proved gastric malignancy, detected on both the miniature and standard examinations."

"The photofluorographic method was satisfactory for detecting certain other types of gastric pathology, but is not the ideal method for x-ray examination of the stomach."

STATE ACTIVITIES

E. J. ILL AWARD TO DR. W. O. WUESTER

In 1939, during the presidency of Dr. Henry C. Barkhorn, the Academy of Medicine of Northern New Jersey established the Edward J. Ill Award in recognition of the outstanding professional attainments of the man for whom it was named. The original description of the Award is as follows: "This Award shall be given at such times as the Council deems wise to that doctor from Northern New Jersey who merits it for his extraordinary services as a physician and as a citizen". The Award has been made on eleven previous occasions, each time to a man distinguished for professional attainments and for contributions to the public welfare. Of the eleven, seven are still living and four were at the presentation to Dr. Wuester. Previous recipients of the Award were:

Wells P. Eagleton	1939
Max Danzis	1941
E. Zeh Hawkes	1942
Arthur W. Bingham	1943
Harrison S. Martland	1943
Henry C. Barkhorn	1944
Edward W. Sprague	1945
Charles H. Schlichter	1946
Clarence R. O'Crowley	1947
Royal A. Schaaf	1948
Henry H. Kessler	1951





Dr. Lewis W. Brown was chairman of the meeting on May 15, 1952, at which the 1952 Award was presented to Dr. Wuester. "The winner of the 1952 Award" explained Dr. Brown, "has made notable contributions to the public welfare. Dr. Schaaf, the 1948 recipient of the Award, will read the citation". Dr. Schaaf then made the following remarks:

"The Edward J. Ill Award of the Academy of Medicine of Northern New Jersey is an honor conferred by the Council and the members of the Academy from time to time upon physicians of our state who not only have attained a certain eminence in the field of medicine but who also have demonstrated an unusual interest in civic affairs or have made a substantial contribution to the welfare of our people. A clear portrayal of the background of the Ill Award for the year 1952 requires a brief review of the history and present status of the Cancer Control Movement in New Jersey.

"In 1925 The Medical Society of New Jersey established an Advisory Committee on Cancer Control as a subcommittee of the Public Health Committee, one of the four major subdivisions of the Society's Welfare Committee. This Committee studies the problems of Cancer Control conscientiously from year to year and accumulated many valuable and interesting data, but accomplished little in the practical way of providing care and treatment for sufferers from cancer. Noteworthy in the work of this committee under the Chairmanship of Henry B. Orton in 1938, was its collection of accurate information regarding cancer facilities of all kinds available throughout the state. Concurrently with the program of The Medical Society of New Jersey, there was considerable activity in the field of Cancer Control on the part of several other organizations such as the Woman's Field Army and the Marie Curie Radium Committee.

Unfortunately these various efforts, although carried on with good intentions by assorted groups of well meaning people, were uncoordinated and lacked definite medical planning and guidance. In 1945, the American Cancer Society burst on the national scene, announcing an ambitious program to raise large sums of money with which to fight cancer on three major fronts:—research, education and service to cancer sufferers, actual and potential.

"The American Cancer Society then began to organize and grant charters to state divisions. The New Jersey Division received its charter on December 26, 1945. Almost at once, two dynamic figures were catapulted into the limelight, and accepted the leadership of this new organization thrust upon them. They were Mr. George E. Stringfellow representing the laymen and Dr. William O. Wuester, the physician. Mr. Stringfellow was the first president of the Division and Dr. Wuester the chairman of its medical advisory committee. These two were an unbeatable combination and their energy, enthusiasm and devotion to the cause of cancer control set an inspiring example to laymen and physicians alike, resulting in morale higher than I have ever seen in any similar voluntary lay health organization. To the planning and execution of the service portion of the program of the New Jersey Division, Dr. Wuester brought a wealth of training and experience in cancer case finding, as well as in the pathology, surgery and radiation therapy of cancer and allied diseases.

"Following a long course of training in the Memorial Hospital for Cancer and Allied Diseases in New York City, in 1937, Dr. Wuester was appointed Director of the James S. Green Memorial Tumor Clinic of the Elizabeth General Hospital, which, under his guidance in the succeeding years has become the largest and most efficiently operated tumor clinic in New Jersey. Dr. Wuester has been a member of the Advisory Committee on Cancer Control of The Medical Society of New Jersey since 1940, serving as its chairman since 1945. For many years Dr. Wuester exercised his fertile brain by conjuring up an ideal cancer control service program. All he needed was a superb organization and large amounts of money with which to carry it out! These were nowhere visible on the horizon until 1946 when the New Jersey Division appeared as the fairy godmother and gave him the opportunity to realize his dream, which included:—

1. An adequate number of strategically placed clinics for the diagnosis and treatment of cancer throughout the state, each clinic to have uniformity in methods, equipment and organization, as well as a competent medical staff.
2. A statewide biopsy service including provision for the examination of Papanicolaou Smears.
3. A home nursing service.
4. Reimbursement of hospitals for laboratory and other diagnostic services to needy persons.
5. Provision of drugs, appliances, dressings and household help for needy patients when required.
6. A subsidy to hospitals providing radio-active isotope facilities and technical information relating thereto. In due time each one of the six parts of Dr. Wuester's envisioned ideal service program, became a reality. Each has been fully described in the 'Six part program for Cancer Control' published in the JOURNAL of The Medical Society of New Jersey. The articles are presented as the cooperative work of the Advisory Committee on Cancer Control of The Medical Society of New Jersey. No special recognition of the major part which Dr. Wuester played in the planning and development of the program is given except that in the list of committee members printed in small type as a footnote to each article, his name appears as the chairman. A perusal of these publications will give the reader no hint of the prodigious personal effort put forth by Dr. Wuester or of the patience, persistence, determination and resourcefulness which he displayed in solving countless knotty administrative problems arising in the course of the development of each part of the service program; no hint of his long, bitter and discouraging battle to gain general acceptance, on the national level, of his idea that the well trained and alert general practitioner is the first line of defense against the cancer invasion and of his idea that the diagnostic cancer clinic as a case finding medium is far superior to the 'cancer detection clinic' (more properly called a 'health maintenance center'). The former type of clinic, by requiring preliminary screening of patients suspected of having cancer, conserves and makes most efficient use of clinical personnel, equipment facilities and available funds; no hint of the ridicule and vituperation which were heaped upon him for his heretical views in this connection; no hint of Dr. Wuester's diligence in ascertaining the minutest detail relating to serviceability, availability and cost of every item authorized for purchase by the medical advisory committee; no hint of his strict economy in the expenditure of available money, whereby he made each $1.00 spent return $1.10 in value; no hint of his vigilance in making certain that the service program did not invade the field of private medical practice by providing free medical and hospital or clinic care for persons who could reasonably be expected to pay for such service without undue hardship, or of his insistence that not a penny of donated funds be used to pay physicians for clinic care given to needy patients; and no hint of Dr. Wuester's prodigious expenditure of his time, his energy and his own money in his peregrinations around the state in the course of ironing out various difficult local problems and in spreading the gospel of Cancer Control.

"The progress in the service program of the New Jersey Division under the medical guidance of Dr. Wuester has been truly remarkable. The service program has made readily available to every person in New Jersey, especially to the needy cancer sufferer and his family, the latest and best means of combating cancer—both by early diagnosis and adequate therapy. There are 39 well organized and conducted cancer clinics in the state, 32 of them having been approved by the American College of Surgeons. Deep x-ray therapy and radium have been made readily accessible everywhere. An efficient biopsy service is functioning; home nursing care is provided along with drugs, appliances, dressings and household help without

charge to needy persons or their families. No hospital is losing money by conducting a cancer clinic and the radio-active isotope program is being developed as rapidly as it appears to be indicated. Certainly, this is a record service to the people of which any voluntary lay health agency can be extremely proud. Many people, both lay and medical, took an active part in the development and direction of this program. When so much has been contributed by so many, it is difficult equitably to apportion credit for accomplishment. Dr. Wuester would be the first to concede that without the superb organization of the New Jersey Division and the funds which it has made available for the purpose, little of practical value in the control of cancer would have been accomplished. Perhaps all of the foregoing remarks could be summarized by stating that the New Jersey Division under the direction of capable conductors, is a splendid orchestra performing a great symphony, the score of which was composed by Dr. William O. Wuester.

"In the opinion of the Council of this Academy, Dr. Wuester, by his planning and guidance of the service part of the Cancer Control Program in New Jersey, has made a magnificent contribution to the public welfare and is eminently deserving of the honor and distinction which we are conferring upon him tonight. I am certain that the audience will wish to know what inscription appears on the face of the plaque. It reads as follows:— *The Edward J. Ill Award to William Otto Wuester, Accomplished Oncologist, Resourceful Administrator, Generous Public Benefactor.*

"Dr. Wuester, on behalf of the Council and Members of the Academy of Medicine of Northern New Jersey, I have the honor and happy privilege of transmitting to you the Edward J. Ill Award of this Academy for the year 1952 and of presenting to you this plaque as tangible evidence of the signal recognition which is being accorded to you on this occasion. With it go our deep appreciation of and lasting gratitude for your unselfish direction of the service part of the cancer control program in this state and your monumental contribution to the health and welfare of our people."

After receiving the plaque, Dr. Wuester replied as follows:

I deeply appreciate the Edward J. Ill award of the Academy of Medicine of Northern New Jersey and am honored to feel that the officers, council and members of the Academy have seen fit to bestow this high honor on a comparative neophyte in the practice of medicine and surgery.

My first experience with cancer control work for The Medical Society of New Jersey was in 1939 as a member of their Cancer Committee, at that time under a mandate of Governor Moore, to report on the cancer situation in New Jersey. Well do I remember the divergence of opinions expressed in these meetings; but upon one phase, all were in complete agreement. This was the establishment of multiple, well equipped, cancer diagnostic and treatment clinics in selected hospitals throughout the state which would act as centers of knowledge and training in cancer for many areas. This plan needed money and with a few exceptions, lay dormant until 1945. This year marked the revitalization of the American Cancer Society as we know it today. Largely through the efforts of George E. Stringfellow, first president of the New Jersey Chapter of the American Cancer Society, the definition of responsibilities in the cancer control program were crystallized. May I quote—

"It is the responsibility of the doctors to advise how, when, and for what medical facilities, programs, and services, money shall be spent. It is the responsibility of the laymen to raise the money and to administer the funds in accordance with sound business practice."

It was in response to this challenge that the greatest cooperative effort between the medical profession and the lay organization has evolved. It led directly, over a period of years, to the evolution and to the publication of the present six parts of our cancer control program for this state. It was largely through the financial help of the Cancer Society that we were able to implement our clinic program, increasing our cancer clinics from 11 to 42, of which 32 are approved by the American College of Surgeons, with the remainder expecting approval as they improve.

During these years, some of them trying, I have derived immeasurable pleasure from my association with many of my medical colleagues and friends in the laity, all vitally interested in our common problem of cancer control. I would be remiss if I did not express my appreciation to those who made it possible for me to be in this position tonight. I am deeply grateful to them.

In response to this citation, it is usually the privilege of the recipient to discourse on some matter closest to his heart—even though it may prove to be controversial. For many years I have been impressed by the thought that the cancer death rate could be lowered considerably if we in the medical profession applied correctly all the present day knowledge regarding cancer in an ever increasing number of hospitals in this state. The question of how this could be implemented is a perplexing one, since it has numerous facets, of which many are not apparent until one considers the problem to some extent.

Tonight I make a plea for the establishment of an in-patient service to be coordinated on

an all year round basis with the out-patient cancer clinics of our hospitals under the supervision of the cancer clinic staff. Greater familiarity with the use of all the modalities of x-ray, radium and surgery as they pertain to the cancer patient will result. This will lead to better care of the cancer patient. Since our hospital clinics are primarily for the medically indigent patient, it will mean a possible conflict with some of the specialty services which feel it their right to treat these cases. On the other hand, no one can deny the soundness of the argument that the patient will get better care if diagnosis, treatment and follow-up, so essential for the cancer patient, are coordinated in one department.

Two rules are suggested which should take care of possible "attending staff" objections:

1. On all ward patients admitted from the out-patient cancer clinic to the in-patient cancer service, a consultation should be required with the interested service; and in the event of surgery, the department in which that type of service falls should have the privilege of assisting.

2. A consultation request should be sent to the cancer clinic service on all general service patients suspected of having neoplastic disease. It remains at the discretion of the chief on service whether the patient is then referred to the cancer service after an opinion is rendered. If surgery is required, the cancer service should have the privilege of assisting.

Due to the great increase in the use of hospital and medical insurance plans, the number of private patients entering the hospital has increased more rapidly than the number of indigent patients. Since the rules above suggested are applicable only to the ward services, I should like to propose the establishment of a "Total Cancer Registry" in each hospital. This would list the indigent and private cancer patients, their diagnosis, form of treatment, and afford a means of periodic follow-up through the physician's office in the case of private patients. This would facilitate critical review of the treatment and end results by a cancer committee appointed by the Medical Board. This would place all cancer work under a brilliant light, the better for all to see and learn. This will help to take cancer therapy out of the shadows.

To stand still at this critical juncture while a greater opportunity for service beckons would be to deny the faith of laity in the excellent progress of mankind's struggle against infirmity. This battle can never be won until the new technics, new therapies and new drugs developed by thorough research have been applied to the test. Nothing can be proved unless tried and analyzed in this light. Progress itself may be trying; but the ultimate goal of conquering this disease should remain a challenge. We cannot fail if we strive mightily to improve on what we already have.

GRADUATE COURSES AVAILABLE AT MT. SINAI

New York Mt. Sinai Hospital announces its usual varied diet of graduate courses on almost all subjects. Some of the newer courses, given in affiliation with Columbia University, are: Metabolic Diseases of Bone and Cartilages; Hematology; Ambulant Cardiology; Spatial Vectorcardiography; Abnormal Physiology; Chest Roentgenology; Gastro-intestinal Roentgenology; Technics of Psychotherapy; Radium Therapy; Elementary Electrocardiography; Ophthalmology; Diet Therapy; Advanced Electrocardiography; Neuroanatomy; Rhinoplasty; Neuropathology; Nuclear Radiation Physics; Otoplasty and Geriatrics.

These are part-time courses, fees varying from $25 to $200. For full details, write to Registrar for Medical Instruction, Mt. Sinai Hospital, 1 East 100 Street, New York 29, N. Y.

GRADUATE WEEK IN NORTHERN NEW JERSEY

The Academy of Medicine of Northern New Jersey announces its Third Annual Graduate Week on November 10 to 14, 1952. A well-rounded program has been arranged by Dr. Murray Shulman and his Graduate Week Committee. Nationally-known speakers will discuss new developments in various areas of medicine and surgery.

All New Jersey physicians and dentists are invited to attend the Graduate Week sessions which will be held at various hospitals in the forenoon and at the Academy each evening. Members of the dental and medical professions are urged to clear their calendars of regular engagements and plan to participate in the full five-day Graduate Week.

Copies of the detailed program will be mailed on request to the Academy Office, 91 Lincoln Park, Newark 5, N. J.

OFFICIAL ATTENDANCE 186th ANNUAL MEETING MAY 19-21, 1952

County	Delegates	Members	Total
Atlantic	9	64	73
Bergen	24	20	44
Burlington	5	18	23
Camden	16	46	62
Cape May	2	5	7
Cumberland	5	8	13
Essex	57	142	199
Gloucester	4	11	15
Hudson	26	41	67
Hunterdon	3	1	4
Mercer	20	53	73
Middlesex	12	43	55
Monmouth	12	43	55
Morris	8	16	24
Ocean	3	6	9
Passaic	20	36	56
Salem	3	4	7
Somerset	4	13	17
Sussex	2	2	4
Union	33	49	82
Warren	2	5	7
Fellows, Officers, Trustees, Councilors	21	..	21
	291	626	917

Physician Guests	78
Physician Scientific Exhibitors	15
TOTAL PHYSICIAN REGISTRATION	1010
Auxiliary Members	323
Visitors	266
Scientific and Educational Exhibitors	23
Technical Exhibitors	173
TOTAL REGISTRATION	1795

FIVE YEAR COMPARATIVE REGISTRATION FIGURES

	Physicians	Others	Total
1952	1010	785	1795
1951	865	699	1564
1950	1019	851	1870
1949	1073	782	1855
1948	1099	774	1873

NEW JERSEY CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

The New Jersey Chapter of the American College of Chest Physicians held its annual meeting at Atlantic City, May 20, 1952, in conjunction with the State Medical Society convention. Dr. Martin Sokoloff, Associate Professor of Medicine, Jefferson Medical College, Philadelphia, spoke of "Recent Advances in Our Knowledge of Pulmonary Emphysema".

The following officers were elected for 1952-1953: President—Dr. John E. Runnells, Scotch Plains; President-Elect—Dr. J. Earle Stuart, Plainfield; Vice-President—Dr. Irving J. Selikoff, Paterson; Secretary-Treasurer—Dr. Samuel Cohen, Jersey City.

H. I. GOLDSTEIN HONORED

Dr. Hyman I. Goldstein, a member of our Camden County Medical Society was honored by the Governor of Mexico City, as a "Distinguished Visitor" and awarded a medal during the recent Congress of Gastroenterology at Mexico City. Dr. Goldstein, an Honorary Member of the Congress spoke on "Some Aspects of Diseases of the Pancreas" and "Some Aspects of Diseases of the Liver and Gallbladder". He also addressed the students of the National University of Mexico, School of Medicine, where he spoke on "Diseases of the Liver and Gall Bladder". He spoke on "Angina Pectoris, and Heart Failure" before the physicians at Acapulco, Mexico. His final lecture was to the Mexican Society of Cardiology on "Some Aspects of Cardiovascular Diseases and Congenital Anomalies".

NEW JERSEY DERMATOLOGICAL SOCIETY OFFICERS

The following officers of the New Jersey Dermatological Society (formerly the Northern New Jersey Dermatological Society) were elected for a term of one year, at the May 13th meeting held at the Academy of Medicine, Newark: President, Eva T. Brodkin, M.D., Newark; Vice-President, Cedric C. Carpenter, M.D., Summit; Secretary, Frederick C. Licks, M.D. South Orange: Treasurer, Harry C. Goldberg, M.D., Plainfield.

THE ANNUAL HARRISON S. MARTLAND AWARD

The Essex County Pathological and Anatomical Society offers a prize of $250 and a certificate of award under the annual Harrison S. Martland Award for the best unpublished paper on pathology or anatomy, or on any of its phases of investigation in the fields of medicine and surgery.

The paper does not necessarily have to be based on original research but may be confined to a review and re-interpretation. The essayist will be known to the committee of judges by number only. Eligibility is limited to resident physicians and interns in the hospitals of New Jersey. The winning author will be invited to present his contribution before the Annual Meeting of the society. The society reserves the right to publish the paper with a footnote indicating that it is the prize paper of the year for this society.

Certificates of merit will be granted to participants whose papers win second and third prizes.

All contributions must be typewritten in English. A paper must not exceed 5000 words. Five copies of each manuscript must be submitted, being mailed not later than October 15, 1952, to Dr. Murray Shulman, at the Newark City Hospital, Newark, New Jersey.

EDWIN H. ALBANO, M.D.,
President

OBITUARIES

ARTHUR P. HASKING

Dr. Arthur P. Hasking of Jersey City died of a cerebral hemorrhage on May 29, 1952.

Dr. Hasking was born in Jersey City in 1879, and received his medical degree from the College of Physicians and Surgeons, Columbia University in 1903. He was associated with the county physician's office since 1905, and was appointed county physician in 1939, a post which he held at the time of his death.

Dr. Hasking was a past president of the Hudson County Medical Society, a Fellow of the American Psychiatric Association and at the time of his death was president of the New Jersey County Physicians' Association. He was attending psychiatrist and neurologist at Jersey City Medical Center and consulting psychiatrist and neurologist at St. Francis' Hospital, Jersey City, and St. Mary's Hospital, Hoboken.

DR. LOUIS J. B. LE BEL

Dr. Louis J. B. Le Bel of Nutley, died on May 21, 1952, after a short illness.

Dr. Le Bel was born in Nutley in 1895, and received his M.D. degree from the University of Virginia in 1921. He was an intern at St. Mary's Hospital, Passaic in 1921-1922, director of dermatology and syphilology there in 1925-1949, and president of the hospital's medical staff in 1931-1935. He was on the staff of the Vanderbilt Clinic, New York, and taught at the College of Physicians and Surgeons of Columbia University from 1926 to 1933.

Dr. Le Bel was a founder and a past president of the Northern New Jersey Dermatological Society. He was a diplomate of the American Board of Dermatology and Syphilology, and at the time of his death was a member of the Council on Medical Education and Hospitals of the American Medical Association.

DR. TRAUGOTT J. SCHUCK

Dr. Traugott J. Schuck of Hoboken, a past-president of the Hudson County Medical Society, died on May 15, 1952.

Born in Hamburg, Germany in 1884, he came to this country at an early age. He was graduated from Columbia University College of Physicians and Surgeons in 1904, one of the youngest men to receive a medical degree at that college. He started his practice in Hoboken in 1908, after interning at Lenox Hill Hospital and Lying-In Hospital. Senior member of the staff at St. Mary's Hospital in Hoboken, Dr. Schuck was in recent years the hospital's consultant surgeon and consultant in obstetrics.

DR. FREDERICK STEIN

Dr. Frederick Stein died suddenly at his home in Lyndhurst on April 21, 1952, at the age of 40.

Dr. Stein was graduated from the Royal College of Physicians and Surgeons, Edinburgh, Scotland in 1941. He was on the staff of St. Mary's Hospital, Passaic.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

The State Department of Health has made public a statement agreed upon jointly by the New Jersey Chapter of the American Academy of Pediatrics and the Child Health Committee of The Medical Society of New Jersey on the relationship between inoculation and poliomyelitis.

Approved by the staff conference of the State Department of Health, the joint statement follows:

"Immunization against diphtheria and whooping cough is such an important public health procedure that it should not be stopped solely on a seasonal basis. Primary immunization in the infant is particularly safe because this age group seldom develops poliomyelitis. Necessary injections, such as tetanus toxoid or antitoxin, penicillin, or hay fever vaccine should always be given. If poliomyelitis is prevalent, routine immunization, except for infants under six months of age, should be abandoned until the epidemic is over."

COUNCIL FOR LOCAL HEALTH SERVICES

Responsibility of the individual and his community for adequate health programs, with the medical profession assisting in control of disease, was emphasized by Aubrey D. Gates, Field Director of the Council on Rural Health of the American Medical Association at the first annual meeting (Trenton, May 28) of the Council for Local Public Health Services of New Jersey.

Mr. Gates' topic was "Health Is Everybody's Business". He was introduced by Herbert W. Voorhees, of Hopewell, President of the Farm Bureau of New Jersey. An abstract of Mr. Gates' remarks follows:

Without the individual assuming primary responsibility for his own health, supplemented by a protective community health program, all the medical assistance in the world is of no avail.

The six points to attain optimum health are:

Nutrition, Environmental Sanitation, Immunization, Medical Care, Hospitalization, and voluntary contributions to agencies such as Blue Cross and Blue Shield.

In rural areas, the medical profession is to be commended for arresting pellagra, with an assist from Agricultural Extension Services, Parent-Teacher organizations and the health and educational professions.

Acceptance of smallpox vaccination should be followed by the public approving other available inoculations to arrest preventable diseases.

The best medical care is obtainable in physicians' offices and clinics, where ancillary equipment is available in contrast to the situations in some rural areas where the general practitioner, lacking such facilities is expected to travel timelessly to administer to the ill.

The location, size and financing of hospitalization are problems for the State Council because they involve the more expensive part of illness. How many hospital beds per thousand population a community needs is still a debatable question. Immunizations and the antibiotics, however, have reduced the average hospitalization from seven to four days. Voluntary hospitalization contribution program is not a problem in industrial New Jersey though presenting difficulties for small business merchants and the individual farmer.

These recommendations for adequate medical care are not a "package solution", but they were offered as a contribution to the work of the new State Council. Find out from the people what their problems are, and the official, non-governmental and civic agencies will be able to solve them.

After adoption of By-Laws, the Council elected the following officers: president, Mrs. Frances Mancusi-Ungaro, Newark; first vice-president, Mrs. Isaac C. Dilkes, Barnsboro, Gloucester County; second vice-president, Dr. Joseph E. Mott, Paterson; secretary, Mrs. Homer van B. Joy, Montclair; treasurer, Theodore D. Vreeland, Princeton.

Members-at-large: Dr. Daniel Bergsma, State Commissioner of Health; Assemblyman C. William Haines, Burlington County; Dr. Harrold A. Murray, Newark; Mrs. Gloanna W. MacCarthy, Maplewood; Dr. Ray E. Trussell, Flemington; Mrs. William C. Leicester, Pittstown; Mrs. C. Spencer Davison, Salem; Dr. William P. Doherty, Bridgeton.

WOMAN'S AUXILIARY

INAUGURAL ADDRESS

Mrs. Edward H. Dyer, Ventnor

I am truly honored to have been elected to represent you as your twenty-sixth president. I accept the responsibilities and the duties that go with this recognition with sincerity and humility. I shall endeavor at all times to speak for you with wisdom and caution, to interpret what you accomplish in a positive fashion and to carry on the fine work of Mrs. McGlade and her predecessors.

It was that honest and irascible fellow, Dr. Samuel Johnson, who once observed, "Life, like every other blessing derives its value from use alone". We should count our blessings; we should also consider how well we are using them.

Our Auxiliary has evolved from a social group into a public service organization. Our husbands are dedicated, as a profession, to the service of mankind. We, as their wives, should be their partners in public service as well as in all the other aspects of life.

It is the request of the Medical Society that each auxiliary become increasingly active in improving the health of its community, and it is important that we work with them as a team. Physicians and their wives should become working citizens of their community. Many busy doctors in the past have not taken time to vote. Let it be a major goal, as good citizens, to see that they exercise the privilege and legal right which keeps us free. And of equal importance, that our families do likewise.

It is in the field of health and medical welfare that you and your husband will be held accountable. Our responsibility is to aid in improving good health and medical services, and we should limit our activities to projects in the field of health. We must be in a position to advise lay groups and offer them our services, attend their meetings and use the opportunities to participate in their educational health programs.

We must educate ourselves to keep our busy husbands informed and up-to-date on current happenings and legislation by reactivating our legislative committees. We must publicize our programs such as Rural-Community Health, Nurse Recruitment, Homemakers' Service, Safety, et cetera, and use the many valuable bulletins and pamphlets the American Medical Association has to offer.

It is you as individuals, who create the inspiration, do the work and achieve the results. We at the state level, can only interpret, publicize, and coordinate your accomplishments, which we in turn pass on to the national auxiliary. Let us try to get to know each other better during the coming year and enjoy the fine friendships we can make in our county auxiliaries, come out to the Public Relations and other health meetings, and try to attend the January open meeting at Trenton. In this way you will become familiar with all the workings of the Auxiliary and realize the scope of its programs.

I do not want to finish without asking you to continue the fine work you have done, or to ask you to become a really active member of your Auxiliary this year. Look ahead and plan for more and better things. We need you, each and every one, to use and protect those blessings which we have been given.

AUXILIARY REPORT

Atlantic County

Mrs. Harry Goodman,
Chairman, Press and Publicity

The annual luncheon of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on May 9, 1952, at Haddon Hall. Some forty women gathered together to honor Mrs. Matthew Molitch, the outgoing president of the Auxiliary.

After a delightful luncheon, elections and installation of officers took place with Mrs. David B. Allman serving as the installing officer. The following were elected to office: President—Mrs. F. Rolfe Westney; President-Elect — Mrs. Herbert Axilrod; First Vice-President—Mrs. E. Harrison Nickman; Second Vice-President—Mrs. William Hersohn; Treasurer—Mrs. Daniel Wilner; Recording Secretary—Mrs. Jay E. Mishler; Corresponding Secretary—Mrs. Neafie Richardson.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, April 11, 1952, at 9 p. m., DR. ANTHONY G. MERENDINO, presiding.

The guest speaker was DR. PRESTON WADE, associate professor of Clinical Surgery, Cornell Medical School. His talk on "Do's and Don't's of Fracture Treatment" was an authoritative presentation of a topic of great interest to surgeon and general practitioner alike.

Dr. Holland reported that the Emergency Medical Service Plan was functioning satisfactorily and that 24 emergency calls had been handled in the past month. Speaking as Treasurer and chairman of the Public Relations committee, he brought up the suggestion that the Society consider the establishment of a permanent home. A committee to investigate the possibilities was urged.

Reporting on Medical Defense and Insurance, Dr. Gleason stated that applicants for professional liability insurance who do special work such as shock therapy, x-ray, et cetera, in their offices would be screened by specialized committees and would need the recommendation of their local Society. This will insure the applicant maintaining minimum requirements in his office.

Dr. Gleason again brought to the attention of the Society the two proposed changes in the operation of Medical-Surgical Plan. The first, regarding the extension of Blue Shield coverage by means of an unlimited income rider at additional premium with a commensurate increase in fees paid to physicians, was unanimously disapproved at the March meeting. The second, on which it was voted that no action be taken at the last meeting, was a proposed plan for the division of surgical fees in accordance with services rendered by auxiliary physicians, and in accordance with a prearranged schedule of fees. It was noted by Dr. Gleason that the proposed change did not apply to combined medical-surgical cases, simple surgical cases, or to a surgeon and his regular assistant. The Medical-Surgical Advisory committee unanimously disapproved the resolution, and recommended that the Society likewise voice its disapproval. It was voted that the recommendations of the committee be sustained and that the Medical-Surgical Plan of New Jersey be so advised.

It was brought to the Society's attention by Dr. Allman that Bill S139, setting up a separate examining board for chiropractors, had passed both houses, and he urged all members to write to Governor Driscoll voicing strong opposition to this dangerous legislation.

Letters from the American Cancer Society and the American Red Cross, requesting organization gifts, were read to the Society. While the worthiness of these two groups was unquestioned, it was felt that it would be unwise to establish such a precedent and the requests were accordingly disapproved.

The President announced with regret the passing of a beloved and esteemed member of the Society, Dr. Isaac E. Leonard, and appointed Dr. Robert Grier to draw up a suitable set of resolutions expressing the deep sorrow that we all feel.

Dr. Sasseen read a comprehensive report to the Society, urging a closer liaison between the Society and the hospital. He moved that a Hospital Expansion committee be appointed for the purpose of investigating hospital conditions and needs. The motion was seconded and carried, and Dr. Merendino stated that such a committee will be appointed.

Dr. McGahn brought up for consideration the establishment of a Medical Forum to be sponsored by the Medical Society. He stated that this would be an excellent opportunity to educate laymen, better public relations, and to propagandize in an ethical way. The President agreed that the idea had much merit and should receive approval of the Society.

Dr. Merendino announced the appointment of a Nominating Committee as follows: Dr. David B. Allman, Chairman; Dr. James Mason, Sr., Dr. William Hersohn, Dr. Clifford Murray and Dr. Harold Bayer.

CAMDEN COUNTY

James P. Harbeson, M.D., Reporter

The *Camden County Medical Society* held its regular monthly meeting on May 6, 1952, with President WALTER A. CRIST in the chair. DR. JOSEPH J. BLAKE was introduced to the society as a new member.

There was no scientific program and the various committees of the society submitted yearly reports, which were approved by the membership at large.

The Nominating Committee's report was read and the following officers were elected for the year 1952-53: President — MARTIN H. COLLIER, M.D.; President-Elect—EDWIN R. RISTINE M.D.; Vice-President—HAROLD K. EYNON, M.D.; Secretary—FRANK J. HUGHES, M.D.; Treasurer—ROBERT N. BOWEN, M.D.; Historian—HELEN F. SCHRACK, M.D.; Reporter—JAMES P. HARBESON, M.D.; Trustee—ROBERT S. GAMON, M.D.; Censor—WALTER A. CRIST, M.D.

Dr. Robert Bowen, Treasurer, gave his annual report and stated that the society was in sound financial position. Dr. Schrack, Historian, reviewed the year's work and their efforts to get photographs of all the members for the society's album.

ESSEX COUNTY

Elizabeth R. Brackett, M.D., Reporter

The April meeting of the *Essex County Medical Society* was held at the Newark City Hospital on April 10, 1952, with the president, DR. KENNETH GARDNER, presiding. After the conclusion of a short business meeting, a "Symposium on Antibiotics" was held, with DR. W. ALAN WRIGHT acting as moderator. Members of the panel and their topics were as follows: BENEDICT F. MASSELL, M.D.,

"Antibiotics in Rheumatic Fever"; LT. COL. EDWIN J. PULASKI, M.D., "Antibiotics in Surgery"; JOHN J. FINN, JR., M.D., "Antibiotics in Septic Meningitis"; B. M. KAGAN, M.D., "Antibiotics in Pediatrics". Presentations and discussions offered a well rounded summary of the present uses and effects of the antibiotics.

The final meeting of the current year was held on Wednesday, May 14, at the Hotel Suburban in East Orange. This meeting was held jointly with the Woman's Auxiliary of the Essex County Medical Society and consisted of a Dinner-Dance with short business sessions conducted by both organizations immediately following the dinner.

The introduction of the new officers, and the remarks of both the new and old officers succeeded the business session.

Music and dancing followed the conclusion of the meeting.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

The Woodbury Country Club was the scene of the April 17, 1952, meeting of the *Gloucester County Medical Society*, with ANTHONY J. DIMARINO, M.D., in the chair.

We were brought up to date on the antibiotics by HARRISON F. FLIPPIN, M.D., associate professor of medicine at the University of Pennsylvania School of Medicine. Dr. Flippin's illustrated presentation of "Present Concepts of Antibiotic Therapy" was comprehensive and very well received by the many members and guests present.

During the business meeting there was quite some discussion about the Chiropractic Bill (S139) and it was decided to have Gloucester County's delegation introduce a resolution at the coming State Meeting advocating the appointment of a full-time medical lobbyist in Trenton. The secretary was instructed to write a letter to Governor Driscoll concerning our opposition to the bill and requesting him not to sign it.

Ralph L. Moore, M.D., discussed another bill which would authorize optometrists to examine the eyes of pupils in the schools. The society backed Dr. Moore in his opposition to this bill and approved of his communicating his views to the Governor.

Drs. R. C. Puff and R. B. Hutcheson were appointed to audit the treasurer's books and Drs. LaRosa, Underwood, and Collins were appointed the nominating committee for our forthcoming society elections.

ANTHONY J. DIMARINO, M.D., presided at the final meeting of the *Gloucester County Medical Society* at the Woodbury Country Club, May 15, 1952.

Chester I. Ulmer, M.D., introduced the speaker of the evening, GARFIELD G. DUNCAN, M.D., Clinical Professor of Medicine at the Jefferson Medical College, and Director and Chief of the Medical Division, The Benjamin Franklin Clinic of the Pennsylvania Hospital. Dr. Duncan learnedly and concisely discussed "Practical Considerations in the Management of Diabetes" with the aid of graphic slides. His bedside test for serum acetone in the diagnosis and emergency treatment of diabetic coma was especially practical.

The Nominating Committee proposed the following slate of officers who were unanimously elected: President—DON B. WEBMS, M.D., Wenonah; Vice-President—RALPH L. MOORE, M.D., Woodbury; Secretary—CLARENCE A. BOWERSOX, M.D., Woodbury; Treasurer—FRANCIS M. BROWER, M.D., Woodbury; Historian—DOROTHY M. ROGERS, M.D., Woodbury; Reporter—LOUIS K. COLLINS, M.D., Glassboro; Trustee (3 years)—CHESTER I. ULMER, M.D., Gibbstown; Censor (3 years)—WILLIAM W. PEDRICK, M.D., Glassboro; Delegate (3 Years)—LOUIS K. COLLINS, M.D., Glassboro; Alternate (3 years)—ISAAC N. PATTERSON, M.D., Westville; Member Nominating Committee—LOUIS K. COLLINS, M.D., Glassboro; Alternate—CLARENCE A. BOWERSOX, M.D., Woodbury.

After being installed in the chair, the new president appointed committees for next year.

Dr. Patterson of the Legislative Committee then discussed the provisions of S.210 which has become law, and suggested that our delegates contact the school physicians present at the Atlantic City meeting in an effort to stimulate agreement on proposed amendments to the bill.

MIDDLESEX COUNTY

George M. Benko, M.D., Reporter

The monthly meeting of the *Middlesex County Medical Society* was held May 28, 1952, at the Roosevelt Hospital, Metuchen. DR. CHARLES H. CALVIN, the president, brought the meeting to order and then introduced GEORGE T. PACK, M.D., Attending Surgeon, Memorial Hospital, New York, the speaker of the evening. Sixty-two members listened with high interest to Dr. Pack's wonderful lecture on the "Recent Advances in the Treatment of Cancer". Dr. Pack expertly elaborated upon the latest modes of therapy and pointed out their possibilities for greater efficiency in the future. He then declared his approval of the present status of surgery and its efficiency in the treatment of cancer.

DRS. G. ROBERT HARDY of New Brunswick and WALTER ZARSKI of South River were elected to Regular from Associate membership; and DRS. THOMAS M. HESLIN, New Brunswick, HOWARD JOELSON and SARA ANN BUNIN, Perth Amboy, and T. LLOYD KOLBAY of Metuchen, were elected to Associate membership.

Dr. Sol Gurshman made a motion that roll call by name be taken at future county medical society meetings. This motion was seconded and passed.

MONMOUTH COUNTY

Sidney M. Hodas, M.D., Reporter

A regular meeting of the *Monmouth County Medical Society* was held at the Marine Grill in Asbury Park, on April 23, 1952, with the President, DR. J. BERKELEY GORDON, presiding.

The meeting was devoted to a consideration of carcinoma of the breast. DR. THEODORE R. MILLER, Assistant Attending Surgeon, Memorial Hospital, New York City, discussed "Surgical Aspects of Breast Cancer" and DR. MAURICE BLACK, Assistant Professor of Pathology, New York Medical College spoke on "Biological Considerations in Breast Can-

cer in Relation to Prognosis and Therapy". Dr. Samuel Rubin served as moderator.

Upon recommendation of the Membership Committee, Dr. George S. Berg and Dr. Jose F. Peitri, both of Asbury Park, were elected to Associate membership.

OCEAN COUNTY

Jesse Schulman, M.D., Reporter

The regular meeting of the *Ocean County Medical Society* was held on May 14, 1952, at Ye Old Cedar Inn in Toms River. The members were treated to an address on "The Use of Radioactive Isotopes in Medical Practice" by Dr. Louis Levinson of Newark, Radiologist to the Newark Beth Israel Hospital and Chief of the Radioisotope Clinic at the hospital.

A business meeting followed the scientific session. The Humphrey Act (an amendment to the Pure Food and Drug Act) which prohibits a pharmacist from refilling a prescription for an item which could originally only be dispensed on prescription unless the doctor indicates that he wants it refilled, was discussed. Members also ordered for display in their offices a plaque prepared by the A.M.A. in the interest of improving relations of the profession with the public.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The annual meeting of the *Passaic County Medical Society* was held on May 27, 1952, at the Medical Society Building, presided over by Dr. Sandor A. Levinsohn, President.

The following officers were unanimously elected: President—Dr. Joseph M. Keating, First Vice-President—Dr. Floyd Fortuin, Second Vice-President—Dr. Leopold E. Thron, Secretary—Dr. Joseph R. Jehl, Treasurer—Dr. Theodore K. Graham, Reporter—Dr. David B. Levine, Board of Censors (3 years)—Dr. Sandor A. Levinsohn.

A recommendation concerning the building assessments was read and passed in the form of a motion: "Building assessments of any newly-elected Active Members, if not paid in full, shall be paid in installments of not less than $20 a year". Dr. Levinsohn then acknowledged the assistance the Woman's Auxiliary gave in furnishing a room in the building. The gift of an ash stand by Mr. Leroy Millar was also acknowledged.

Robert A. Hingson, M.D., presented "A Summary of Modern Obstetrical Analgesia and Anesthesia Based on a Four Year Johns Hopkins University 15,000 Case Study". It was the first preliminary report of this work given by Dr. Hingson and was exceptionally interesting and well received.

UNION COUNTY

Leslie M. Townsend, M.D., Reporter

Our new president, Dr. Emanuel M. Satulsky of Elizabeth, presided at the May 14 meeting of the *Union County Medical Society* held at the Johnson and Johnson Auditorium in Cranford. In continuation of the effort to include more general topics in our meetings the program for this meeting was a delightful informal discussion of past experiences by Dr. Mal Stevens who is former head football coach at both Yale and New York University and who now is an attending orthopedic surgeon at the Sister Kenny foundation of the Jersey City Medical Center. Dr. Stevens mentioned only in passing his own contributions in the orthopedic surgical reparative procedures for athletic injuries particularly of the knee and shoulder joints. Anecdotes and reminiscences of his experiences while coach sparked his talk. Dr. Stevens loves athletics and emphasized the value and necessity for continuous conditioning on the part of the athlete for his own safety.

Before adjournment a short business meeting followed, at which final action was taken on the resolutions from our Society to be presented at the 186th Annual Meeting of The Medical Society of New Jersey.

BOOK REVIEWS

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of Northern New Jersey

The Serpent-Wreathed Staff. Alice Tisdale Hobart. Pp. 403. Indianapolis, Bobbs-Merrill Company, 1951. ($3.50)

If Mrs. Hobart had managed to devise a suitable ending about sixty pages sooner than she did, a critic would be able to say that she had written a faulty but highly interesting story of human conflicts and loyalties. As it is, however, the latter part of the book is simply a propaganda piece for national compulsory health insurance. The last forty pages sound as if Mrs. Hobart knocked them out hastily at a desk piled high with pamphlets, speeches and news releases handed out by Oscar Ewing and the Committee for the Nation's Health.

The author is at her best describing the personal problems and struggles, the emotional triumphs and defeats of her principal characters. On this fictional level the book has merit and strength, for the reader finds himself sharing the fears, anxieties and grief of the people in the novel.

Central figures in the story are two brothers, Dr. Alan Towne and Dr. Sam Towne, grandsons of old Dr. Samuel Towne, who had achieved medical eminence only after many years of struggle and criticism because of unorthodox ideas. Sam, the older brother is successful, wealthy, conservative. Alan is drawn as the idealistic, progressive pioneer, striking out in new and dangerous directions and carrying on in the tradition of his grandfather.

Main action of the novel begins shortly after the end of World War II when Alan leaves a comfortable, assured partnership with Sam to start a group practice. From then on the troubles and tragedies mount in rapid sequence and growing complexity.

Mrs. Hobart gives the impression that group practice, health insurance plans, preventive medicine and similar ideas are brand new developments —practically untried and unheard of in a present-day American city. Actually, most of the concepts and projects which occur to Alan Towne, in sudden flashes of inspiration, are part of the knowledge of any alert medical student. The industrialists and businessmen on Alan's hospital board are utterly untypical when they talk as if they had never heard of health insurance for their employees.

Before Mrs. Hobart writes another novel on this subject, someone should familiarize her with the major facts and realities in the field of modern medical economics. Someone should tell her about the many clinics and other forms of group practice in successful operation throughout the country, some of them since around the turn of the century. She should be told about the hundreds of fast-growing, constantly-improving voluntary health insurance plans, which by the end of this year will be protecting 90 million Americans against the major costs of illness and accidents. One wonders why she never heard of the nationwide progress of state and county medical societies in setting up doctor placement programs, grievance committees, emergency call systems, cost adjustment committees, local health units and a variety of other activities designed to make good medical care available to all the people.

After only three years of struggle in group practice and as head of a group hospital, Dr. Alan Towne is an advocate of government health insurance. Apparently neither the author nor the good young doctor sees the glaring contradiction between government medicine and Alan's own philosophy of careful, personalized treatment of the whole patient, in mind and spirit as well as in body.

Read simply as a novel, this is a moving, absorbing story. But as a source of information affecting public opinion on medical-economic issues, it is an example of careless, superficial writing, with a built-in conclusion contrary to the convictions of the great majority of Americans today.

F.B.E.

Pathology of the Fetus and the Newborn. By Edith L. Potter, M.D. Pp. 574. Chicago, The Year Book Publishers, 1952. ($19.00)

The pathology of the fetus and the newborn is often neglected, principally because the changes that occur in the infant's brief life are meager and readily overlooked. These changes are present, however, and when properly correlated with the conditions present before death, will stimulate preventive measures.

The volume is divided into 28 sections beginning with "Development of the Fetus and Placenta" and ending with "The Blood". It includes such section titles as Birth Trauma, Infections, Disturbances of each organ and system. The complete result is good and the format is such that it reads comfortably.

Sources are varied and the sampling widespread. Over 6000 autopsies done at the Chicago Lying-In Hospital, and 3000 autopsies performed by the Chicago Department of Health as well as a review of 10,000 protocols from other Chicago hospitals, were investigated. The material rarely includes children over one year of age being almost limited to the fetus and the newborn. Material is also reported upon from various parts of the world. The illustrations are ample and excellent.

The author points out that not until the seventh month of gestation (when fetal weight is about 1000 Grams) is the growth of lung capillaries enough to come into adequate contact with the potential air spaces. It is this physiologic maturity which insures adequate function which can sustain life.

The chapter on "Causes of Fetal and Infant Death" is too brief and could have been better organized. This is a book not only for the pathologist but also for the pediatrician and the obstetrician. Its coverage is complete. It fills a great need in the modern medical library and much credit must be given to the author.

MURRAY W. SHULMAN, M.D.

The Other Child. Richard S. Lewis, Alfred A. Strauss and Laura E. Lehtinen. Pp. 108. Grune and Stratton. New York, 1952. ($2.50)

A rare combination of emotional understanding and scientific objectivity characterizes this unique volume. It explains to parents and other laymen the nature of mental and emotional disturbances associated with early brain injury. One of the authors is the parent of a brain-injured child, and a professional writer; the other two are technically skilled officials of a special school for the training of such children. While not offered as a therapeutic manual, it does contain numerous hints on the management and education of this special group of children. It is the kind of volume a pediatrician, neurologist or family doctor may recommend to the parents of brain-injured children; and it is an excellent source book for lecturers to the laity on that subject.

SAMUEL POLLOCK, M.D.

The Merck Index. Pp. 1167. Ed. 6. Rahway, N. J. Merck and Company, Inc., 1952. ($7.00)

More than 8000 chemicals and drugs are described with telegraphic compactness, yet with encyclopedic coverage in this unique volume. Primarily a reference source for the pharmaceutical chemist, the *Merck Index* will be a valuable tool for the medical practitioner who has a more than superficial interest in the pharmacognosy of the drugs he uses. For example, the busy physician may be content to know only the dose and therapeutic effects of, say, amphetamine. A small proportion of practitioners, however, will have enough

intellectual curiosity to wonder about the chemical formula, the way the drug is prepared, the many trade names under which it is marketed, the official chemical name, the earliest publications dealing with the drug, its solubility, boiling point, et cetera. Obviously this kind of detail will not fascinate most doctors. But to the small group of physicians who do have an interest in the chemical background of the drugs they use, the *Merck Index* is the best single informational source.

The book is enhanced by the publication of numerous tables, including a periodic chart of the elements, logarithms, toxicologic information, percentage solution tables, specific gravities, melting points, conversion tables, isotopes, organic reactions with eponyms, standard buffers and various other tables useful to the chemist.

VICTOR HUBERMAN, M.D.

Rheumatic Diseases—Based on the Proceedings of The Seventh International Congress on Rheumatic Diseases. Committee on Publications of the American Rheumatism Association: Charles H. Slocumb, M.D., Chairman. Pp. 449. Philadelphia, W. B. Saunders Company, 1952. ($12.00)

The authors have done a tremendous piece of work on this superlative reference book on rheumatic diseases. In the greater sense, it is not a standard textbook, and will be of scientific interest not only to the general practitioner, but also to the internist and especially the rheumatologist. This excellent and scientific volume will stimulate further thought and research.

Most of the papers were presented at the Congress on Rheumatic Diseases in 1949. It is most unfortunate that three years elapsed between presentation and publication. Much of the thought has since undergone great revision. Concepts of cortisone and ACTH reflected in this volume need revision and modification. Histology and biochemistry of connective tissue are very adequately covered; in fact so adequately, that it tends to be wordy in places.

The general arrangement is excellent. The charts and photographs are clear, well printed and easily understandable. Every student of rheumatic diseases should own this excellent volume and should look forward to comparison with the review of the Eighth International Congress on rheumatic diseases to be held in 1953.

HERMAN H. TILLIS, M.D.

A Textbook of Clinical Neurology; with an introduction to the History of Neurology. By Israel S. Wechsler, M.D. 7th ed. Pp. 801 with 179 figures. Philadelphia, W. B. Saunders Company, 1952. ($9.50)

Since its first edition, Wechsler's *Textbook of Clinical Neurology* has been widely used by medical students and general practitioners. The general acceptance of this volume has been fully justified by the content and the approach. There are more detailed textbooks of neurology; some are better illustrated; some have individual chapters of greater merit. However this is probably the most solid and valuable textbook of neurology now available.

The 7th edition contains many changes. The text has been improved and modernized and much obsolete material has been removed. The revision has been so complete that in many ways this is a new textbook. The treatment of meningitis (especially tuberculous meningitis) has been brought up to date. The treatment of neuro-syphilis has been thoroughly revised and recently developed attitudes have been incorporated. The chapter on the neuroses has been rewritten. This has always been the weakest chapter in the textbook. It is doubtful whether it belongs in a textbook of neurology.

The preliminary chapters on history taking and the neurological examination and the interpretation of signs and symptoms are very well written and are practically a required reading for medical students. The chapter on psychologic diagnosis (written by David Wechsler) is well done but its inclusion in a textbook of neurology is open to question. The book closes with an introduction to the history of neurology. In 35 pages Dr. Wechsler has given the reader a splendid survey of the history of neurology. He has made this difficult subject come to life. As a whole, the book offers a reasonable balance between conciseness and detail. There is no padding and the bibliography is reasonably complete. It is difficult to conceive of a medical bookshelf that does not contain Wechsler's *Textbook of Neurology*.

LEWIS H. LOESER, M.D.

Handbook of Cardiology for Nurses. By Walter Modell, M.D. 246 pp. New York, Springer Publishing Co., Inc., 1952. ($3.50)

Specialization is here to stay. The tentacles of selectivity have reached into the nursing profession, as is exemplified in this *Cardiology for Nurses*. Whether one does or does not agree on the subject of specialization, it must be admitted that this is a unique book. It is well written by an experienced teacher who presents cardiology as the nurse should know it to manage her patient with skill and efficiency. Thus, the text tells precisely about the types of heart disease, the signs and symptoms expected and the diagnostic procedures employed. It explains the nurse's part in performing these procedures as a skilled technician.

The sections on general nursing care and cardiac drugs enable the nurse to follow any therapeutic plan with any doctor and still feel "expert" in each case. The book rationalizes the potentialities of surgery in heart disease. It gives sensible advice in the psychotherapeutic management of the cardiac patient.

This treatise should be in the library of every nurses' training school. It offers students and their teachers sound instruction about a disease in which expert cooperation by the nurse is mandatory for successful treatment and rehabilitation; for the graduate nurse, this book is a reliable review of all phases of heart disease. For the one who specializes in cardiac nursing, it is an indispensable reference.

EDWARD C. KLEIN, JR., M.D.

TUBERCULOSIS

ABSTRACTS

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV July, 1952 No. 7

INCIDENCE OF PULMONARY TUBERCULOSIS AMONG EMPLOYEES IN 14 INSTITUTIONS FOR THE MENTALLY ILL

By Julius Katz, M.D., Robert E. Plunkett, M.D., and Frederick MacCurdy, M.D., The Psychiatric Quarterly, July, 1951.

A tuberculosis control program in the 27 institutions of the New York State Department of Mental Hygiene was inaugurated in the fall of 1941 with the X-ray examination of all patients and employees. These surveys disclosed hitherto unknown cases of pulmonary tuberculosis and resulted in patients with clinically significant pulmonary tuberculosis being segregated and employees with active tuberculosis being referred to tuberculosis hospitals.

To prevent the admission of unknown cases of tuberculosis among new patients and employees, routine X-ray examination of patients at the time of admission and of employees at the time of beginning employment was begun immediately after the initial survey. As a result, the pulmonary status of all patients and employees is now known.

The control program also includes X-ray resurveys of all institutions at an interval of about four years. The periods between X-ray examinations in individual employees varied from a few weeks to almost five years. The frequency of X-ray examination of employees on the tuberculosis wards did not differ significantly from those on other wards.

Eleven of the institutions covered by this report are hospitals for mentally ill patients, while the three others are state schools for mental defectives. Ten of these have special wards or buildings for the care of tuberculous patients. The others transfer their tuberculous patients to institutions with tuberculosis wards.

Employees were considered as having newly developed pulmonary tuberculosis only when the X-ray film showed evidence of clinically significant tuberculosis following one or more previously negative films. Those whose initial films were considered suspicious for reinfection tuberculosis, or for pleural effusion, were not included in this study. The diagnosis of tuberculosis was made by X-ray examination alone. Later study during hospitalization in tuberculosis hospitals usually verified the diagnoses.

Employees were divided into two groups as follows: (1) Employees having four weeks or more total time on duty in a tuberculosis ward are considered as having been occupationally exposed to tuberculosis; (2) Employees on duty in wards or buildings in which there were no known cases of tuberculosis, or who had less than four weeks of exposure. During the period covered by this report, the average number of positions in the 11 institutions included was 9,996. These positions were filled by 22,072 individuals, for an average length of employment of 2.2 years.

RESULTS

The incidence of pulmonary tuberculosis was higher among employees in the hospitals than among those in the state schools, 1.10 and 0.31 per 1,000 person-years respectively. There was no significant difference in the total rate between males and females. Among hospital employees the total incidence rate was 7.43 per 1,000 person-years among those working on the tuberculosis wards, as compared with 0.83 among those not exposed to known cases of tuberculosis among patients, a ratio of almost 9 to 1. The rate among exposed male employees was 11.35 per 1,000 person-years, that among the non-exposed 0.75.

Among females the rates were 4.12 and 0.91 respectively. Thus, the rates were about 15 and five times as high, respectively, among males and females employed on the tuberculosis wards of the hospitals as among those not thus exposed. These differences are statistically significant. The rates among employees in the state schools were also higher among those occupationally exposed to tuberculosis, but the numbers are too small to be of statistical significance.

For the proper evaluation of the incidence rates, comparisons should be made to determine, first, whether tuberculosis incidence rates among those not employed on the tuberculosis wards are higher than among groups similiarly employed, but among mentally normal patients, or in occupations considered to be free from tuberculosis hazards; second, whether the rates among employees on the tuberculosis wards are excessive as compared with groups caring for mentally normal tuberculous patients.

There is little information regarding the tuberculosis incidence rate in the general population. However, an estimate of this rate may be made from the number of cases of tuberculosis reported annually. While the cases reported in any given year do not necessarily represent those that develop during that year, nevertheless, over a period of time, it may be considered an approximation of the rate of development of new cases. The table shows the reported case rates per 1,000 population 15 years of age and older in upstate New York for the period which corresponds approximately to that during which the 14 institutions were surveyed:

1941	0.98
1942	1.16
1943	1.12
1944	1.00
1945	0.88
1946	1.00
1947	0.95
1948	0.95
Average	1.00

The tuberculosis incidence rate of 0.72 per 1,000 person-years among all institutional employees not working on the tuberculosis wards compares favorably with the rates mentioned in other studies and in the general population, and indicates the absence of any unusual tuberculosis occupational hazard involved in the care of these mental patients.

It has been pointed out that employees, such as attendants and nurses, providing direct service to patients on the general wards had higher incidence rates than those providing less direct patient service, such as clerks, maintenance workers, and others. This would seem to contradict the statement that there is no unusual occupational hazard involved in the care of mental patients on these wards. There is, of course, danger of developing tuberculosis as the result of contact with patients among whom sporadic cases of infectious tuberculosis may develop which are not detected for some time. This is probably the cause of the higher rate among attendants and nurses. However, this danger is not limited to employees of mental institutions. In *any* group of employees, those whose occupation includes contact with tuberculous individuals will be expected to have higher incidence rates than those who are not subject to such exposure. The fact that the *total* incidence rate for employees of these institutions is essentially the same as that obtained among other occupational groups indicates that there is no excessive occupational hazard among these employees.

The results of the study indicate that the phases of the tuberculosis control program in mental institutions which need emphasis are as follows: a. To decrease the relative number of employees exposed to tuberculous patients, the concentration of these patients in a few tuberculosis centers should be accelerated. b. Employees on tuberculosis wards should be kept under close medical observation with frequent, periodic chest X-ray examinations. c. Training in infectious disease techniques should be given to all nurses, attendants, and other employees working on tuberculosis wards.

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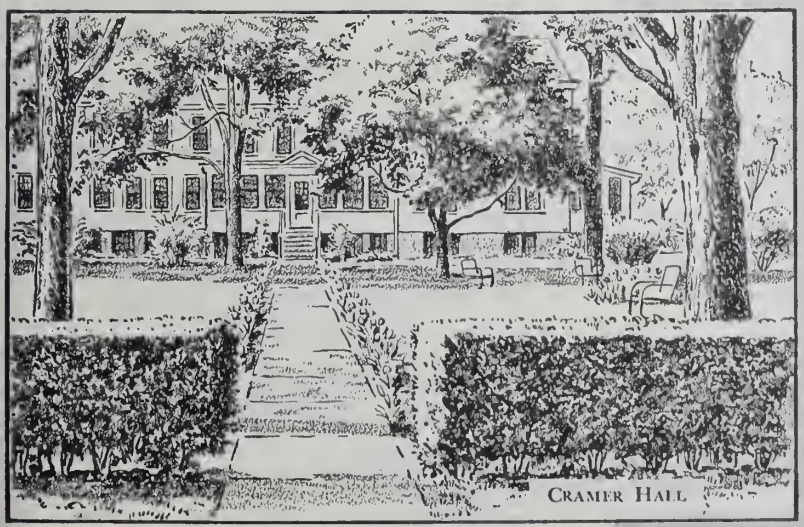
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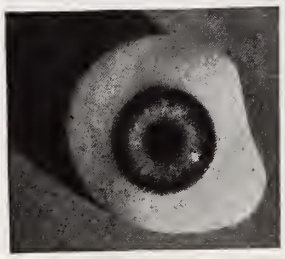
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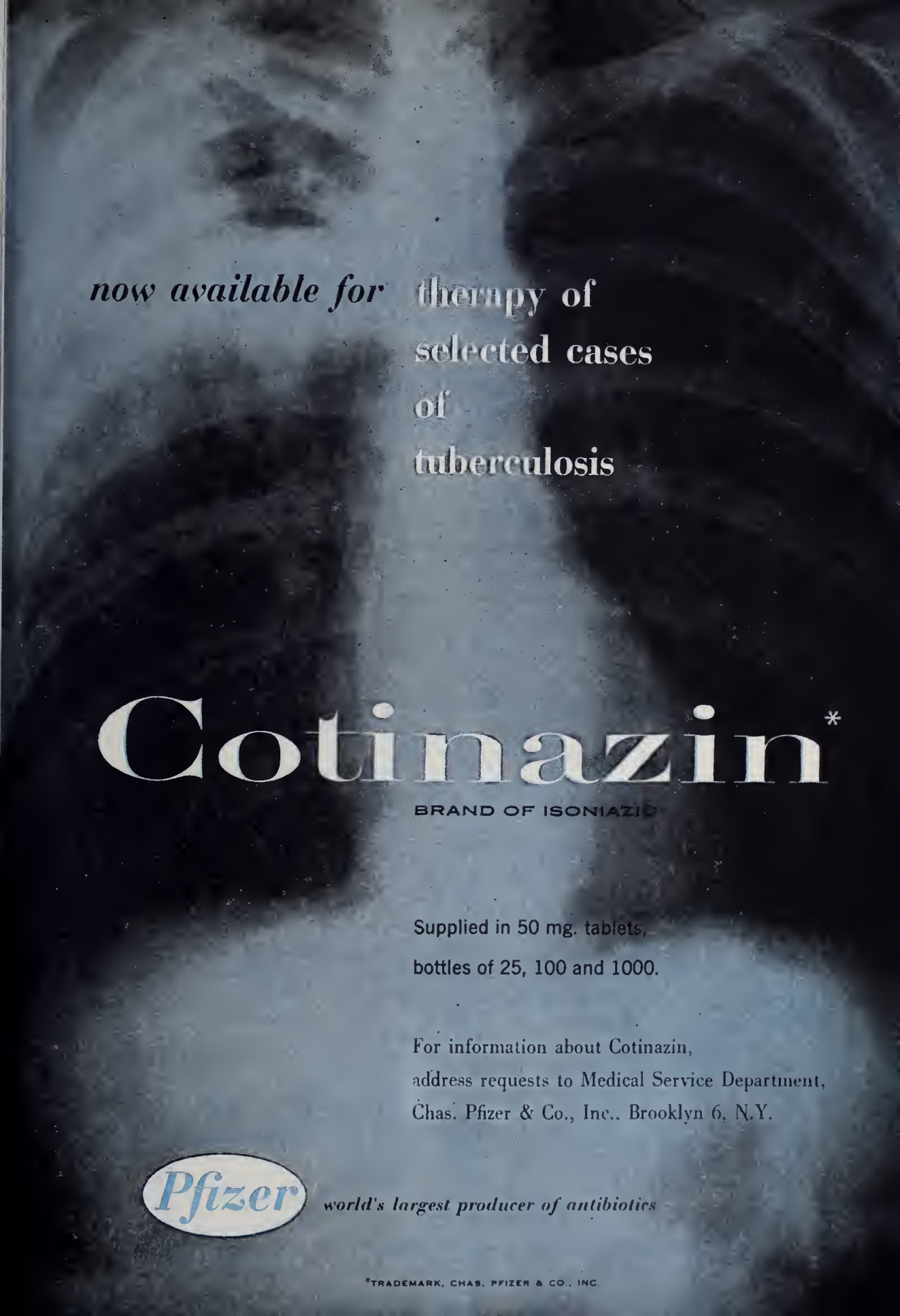
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(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

in hay fever



Pyribenzamine®
unsurpassed

as an antihistaminic agent

And the same is true in the many other allergic manifestations in which antihistamines are prescribed: *allergic rhinitis, serum sickness, angioneurotic edema, drug reactions, and itching skin conditions such as atopic and contact dermatitis and urticaria.*
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Again and again, unsolicited comments like the one above emphasize how the Photrometer speeds up routine clinical tests, while insuring maximum accuracy. Satisfied users repeatedly acclaim it as the most highly selective and accurate photoelectric colorimeter available.

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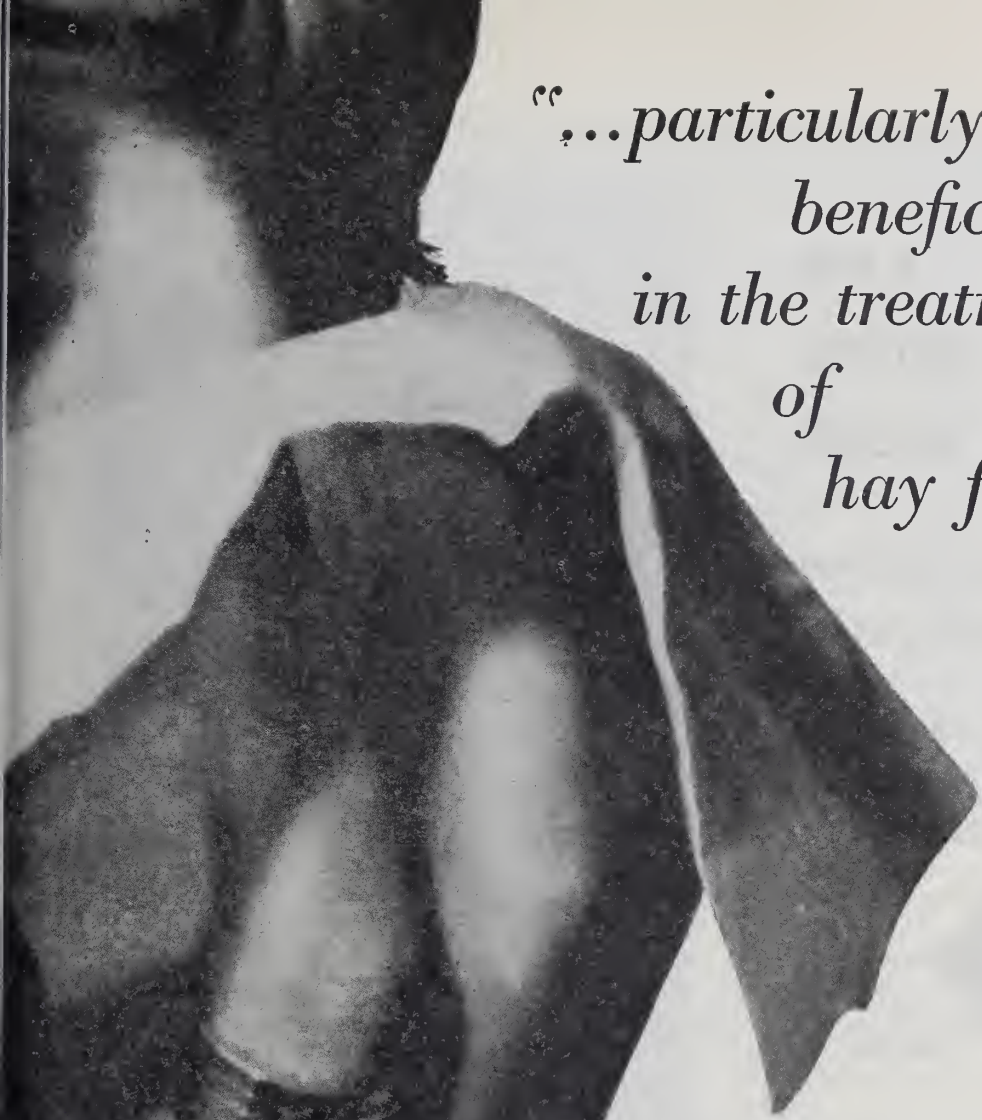
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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26, 1950.

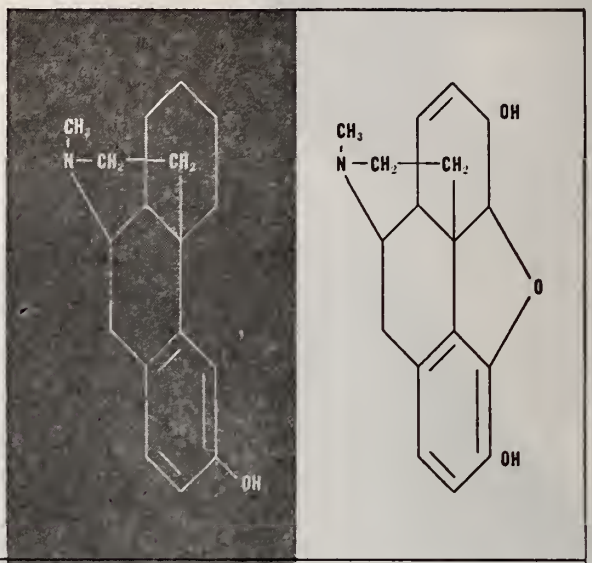
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SIDE EFFECTS	DROMORAN *Dose: 5 mg (1/12 gr) Pain Relief: 6 to 8 hrs	MORPHINE *Dose: 15 mg (1/4 gr) Pain Relief: 4 to 6 hrs
diminished urine	rare	frequent
constipation	rare	frequent
disorientation	rare	frequent
depressed appetite	rare	frequent
nausea	less	occasional
vomiting	less	occasional

Caution: Dromoran is a narcotic analgesic. It has addiction liability equal to morphine and for this reason the same precautions should be taken in administering the drug as with morphine.

DROMORAN®—brand of methorphinan (dl-3-hydroxy-N-methylmorphinan)

* *Average dose*

DROMORAN

(dl) Hydrobromide

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Salt is what makes things taste bad when it isn't in them.*

Most people find foods unappealing and insipid without salt. Therefore, when salt restriction is indicated, the patient must be impressed with the importance of a salt-free diet and must adhere faithfully to a rigid regimen. "With the development of such preparations as Neocurtasal . . . the problem of palatability and a salty taste has been fairly well solved . . ."[1]

Neocurtasal®

". . . trustworthy nonsodium-containing salt substitute" [2]

—lends the desired salty flavor to foodstuffs, and can be used in all salt-free and low sodium diets.

CONSTITUENTS: Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate and starch.

and

NEOCURTASAL
Iodized
(contains potassium iodide 0.01%)

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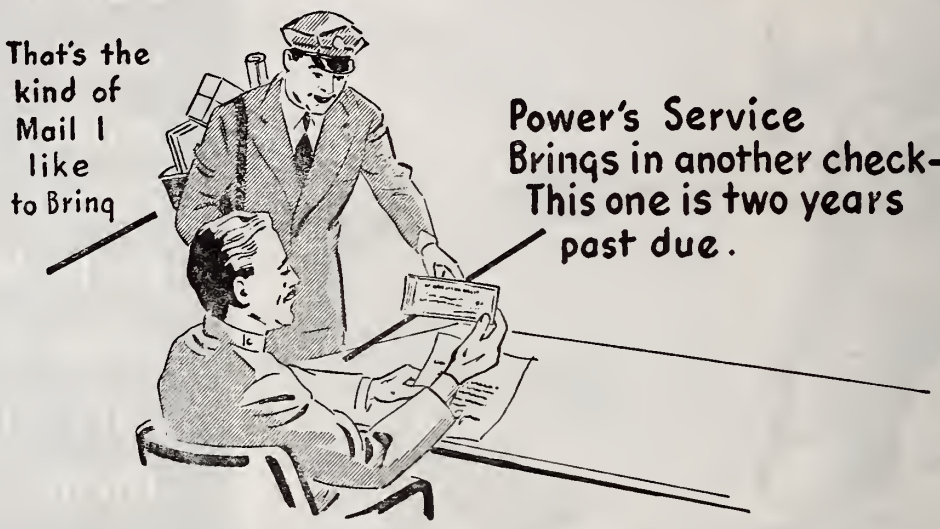
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Both available in 2 oz. shakers and 8 oz. bottles.

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1. Merryman, M. P.: The Use of the Low Sodium Diet. *South Dokota Jour. Med. & Pharm.*, 2:57, Feb., 1949.
2. Heller, E. M.: The Treatment of Essential Hypertensian. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

*Authar unidentified. Fram Mencken, H. L.: A New Dictionary of Quotations. New York, Alfred A. Knopf, 1942, p. 1057.



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1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February.
2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August. 3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.



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A NATURAL Treatment for Simple Constipation

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Acidophilus In Connection With Food Allergies and Antibiotics

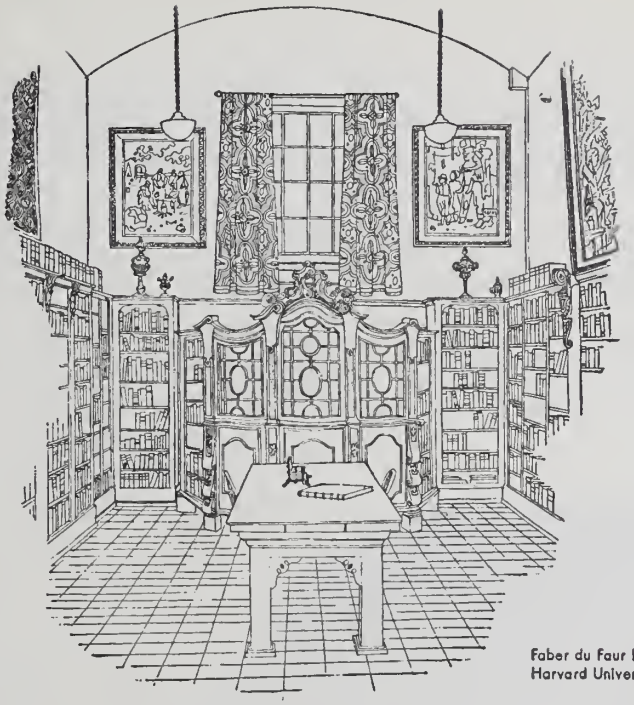
Considerable medical interest is being shown in these uses. A report on research now underway, "Acidophilus Milk and Food Allergy," also reprint, "Antibiotics Warning," will be sent to you on request.

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AUREOMYCIN

Hydrochloride Crystalline

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Aureomycin has been reported to be useful in infections commonly seen by urologists, including:
Genitourinary infections caused by *E. coli*, *A. aerogenes*, *S. faecalis*, paracolon bacillus, staphylococcus, streptococcus, and enterococcus • Chronic or Resistant Urinary Infection* • Gonorrhea • Nonspecific Urethritis*

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(PYRILAMINE MALEATE, MERCK)

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Research and Production for the Nation's Health

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Manufacturing Chemists

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so we had to make it

Doctors have always wanted a formula for infant feeding that would be as close to human milk as nutritional science could provide.

The problem was immense; the requirements were rigid; the need was great. Borden took up the challenge, and after years of research and many trials and clinical tests the goal was accomplished. BREMIL was made available to the profession.

BREMIL is the first and, to date, the *only* infant food to achieve *all* of these prescription requirements:

- . . . conforms to the fatty acid pattern of human milk
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- . . . has a calcium-phosphorus ratio (guaranteed minimum 1½:1) adjusted to the pattern of human milk to prevent tetany
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Bremil® *powdered infant food*

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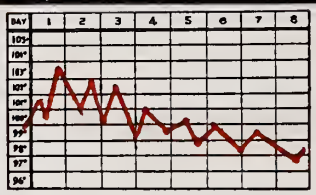
Pyelonephritis

1 Pyelonephritis occurs most often in the young child . . .

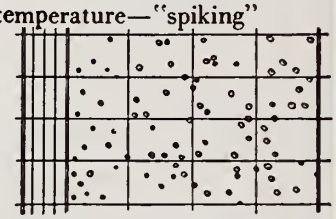


commonest in the "diaper age" female

2 The onset is sudden, usually with a chill . . .



. . . temperature—"spiking"



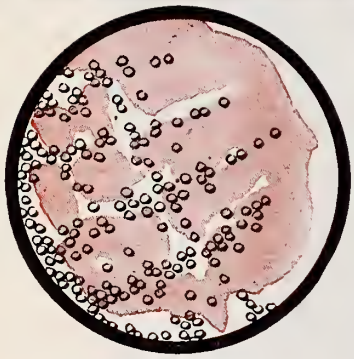
. . . white cell count—high

3 Always, pus cells and bacteria pear in the urine



look for *clumps* of white cells in *catheterized* specimens

4 Culture determines pathogen. Mixed infection not uncommon.



in 8 out of 10 children, colon bacillus invades

5 Sometimes there is tenderness over the kidney region . . .



try the McKnight punch, or



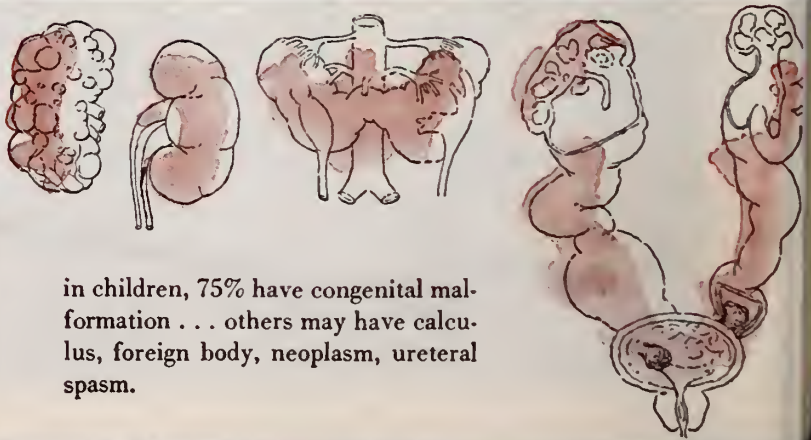
palpation in C-V angle

6 . . . or abdominal pain and rigidity



suggestive of an acute abdomen

7 Look for a cause of urinary stasis.



in children, 75% have congenital malformation . . . others may have calculus, foreign body, neoplasm, ureteral spasm.

CRYSTALLINE

Terramycin

Many urinary tract infections
as well as other infections
rapidly respond to therapy
with this well-tolerated
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Available in a wide variety of convenient dosage forms.

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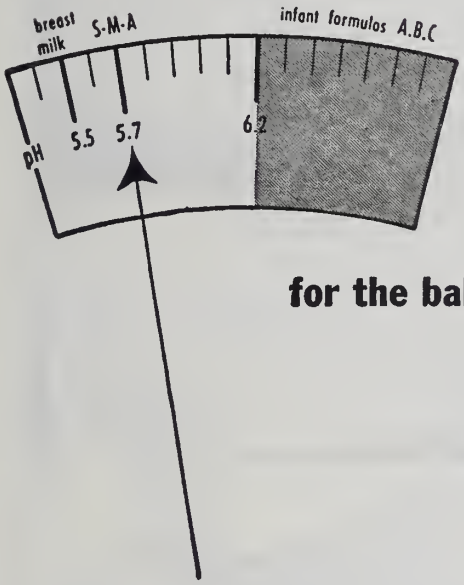
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- establishes a predominantly gram-positive flora—similar to the flora of the lower intestine of the breast-fed baby.[1]



- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

for the baby S-M-A means:

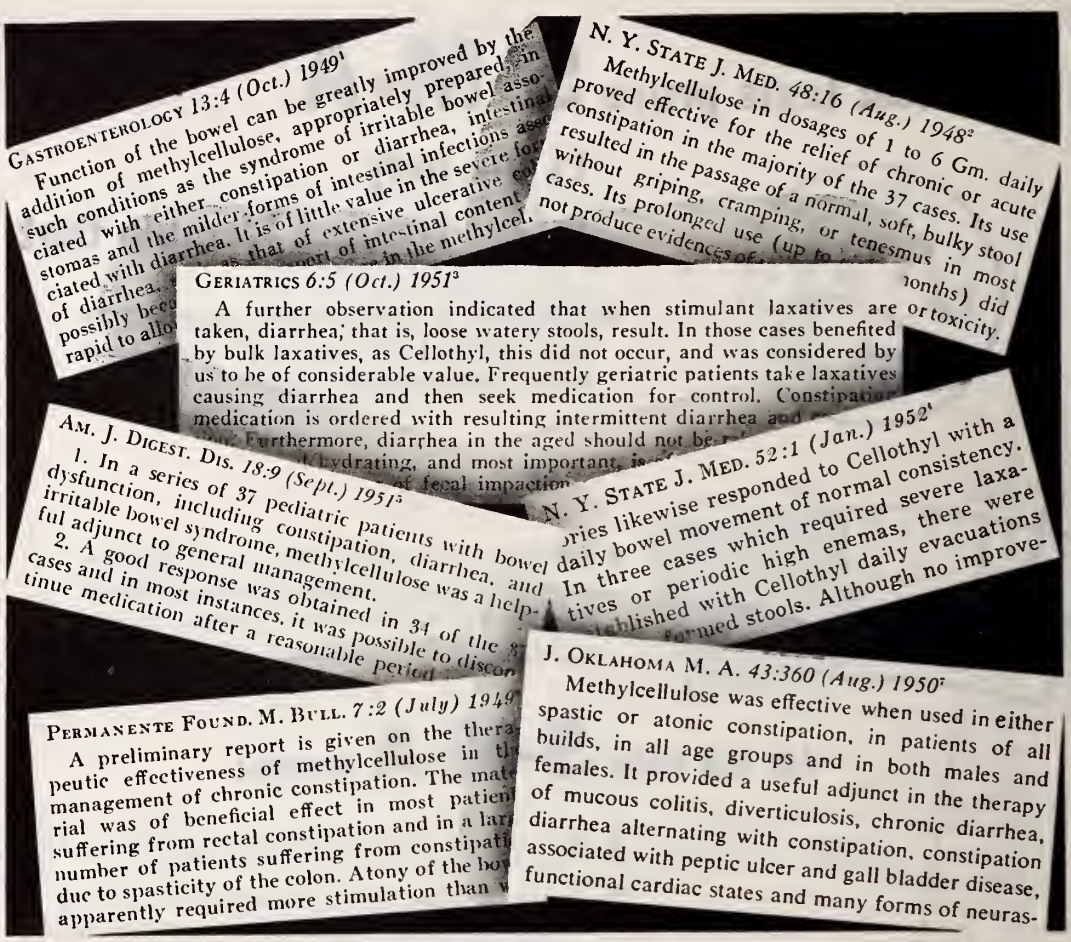
1. *Better absorption of minerals, especially calcium.*
2. *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.
3. *Lessened susceptibility to diarrhea.* Lactobacilli inhibit overgrowth of 'colon' group bacilli.
4. *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.
5. *Vitamins more readily available, especially vitamin* B_{12}. Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.
6. *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

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3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.

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Bibliography: 1. Bargen, J. A. 2. Schweig, K. 3. Wechsler, L.; Kessler, L. A., and Goldsmith, M. F. 4. Keeler, K. C., and Rusk, H. A. 5. Seidmon, E. E. P. 6. Newey, J. A., and Goetzl, F. R. 7. Musick, V. H.

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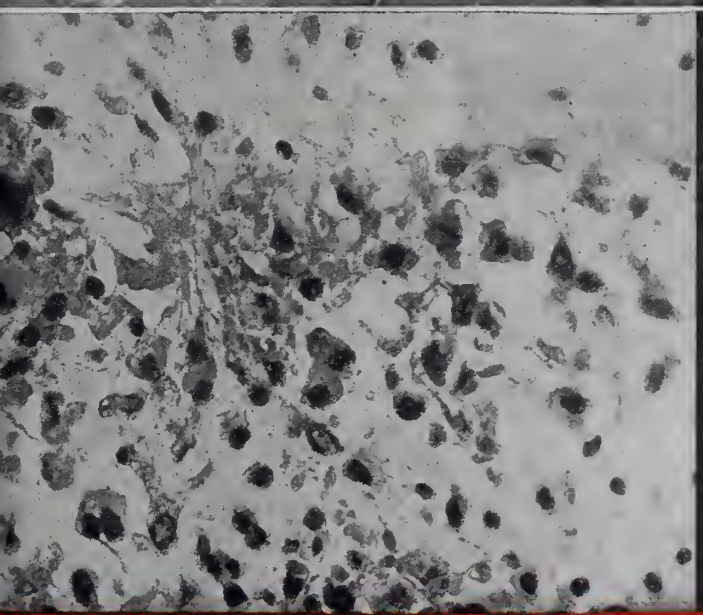
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PRESIDENT'S MESSAGE

PUBLIC RELATIONS—YOUR PERSONAL RESPONSIBILITY

Some members of our Medical Society think that a good public relations program consists of an elaborate set-up with an expert professional staff, super-salesmen so to speak, distributing many multicolored pamphlets, entertaining the press, legislators and many non-professional agencies at costly dinners—all designed to impress the public with the importance of our many worth-while projects.

This idea is completely wrong. We may use all these adjuncts; but they will be impressive only to the degree in which our behavior as ethical practitioners is convincing to the community in which we live.

"Your Public Relations is Showing—Doctor" might well be applied to all of us, when we forget that it is our solemn obligation to do at all times the things that are expected of us as educated, cultured members of an honored profession.

Your Public Relations Committee is working earnestly to bring to your attention the important role that *you* must play in its program this year. You will be reminded of this duty often and in many ways. Because of our busy schedules, some of us forget these important obligations. If we are to enjoy the distinction and respect that are our right, we must continue to hold—and in some cases regain—the esteem which our fellow-men have for us as physicians. We have certain definite duties and privileges as practitioners in a community:

First, we must see to it that our practices are covered by competent colleagues when we are away.

Second, we must be available in emergencies.

Third, before initiating treatment we must discuss the cost of medical and surgical procedures with our patients.

Fourth, we must adjust our fee for services to the patient's income.

Fifth, we must willingly enter into the planning for all health programs, especially those which include medical services.

A good and effective public relations program is dependent on all these requisites. And we alone can make them possible. A dynamic personality or a well-planned press release may tell in convincing terms that these are our ideals and objectives; but if we do not demonstrate by our actions that, as individual physicians, we are willing and eager to render these fundamental services which we are pledged to perform, then any program for good public relations will fail, no matter how well organized or at what great cost.

The public, especially the supporters of socialized medicine, must be convinced by our actions that we are members of a great profession with so many worth-while positive programs to offer the citizens of our state and that we will render adequate medical care to everyone at all times within their ability to pay for this care.

This is your personal responsibility and opportunity, Doctor.

Harrold A. Murray, M.D.

THE NEW ANTITUBERCULOSIS DRUGS

The introduction of the isonicotinic acid hydrazide compounds in the treatment of tuberculosis was attended by a deplorable type of publicity. The daily press headlined that a new miracle drug had been found for the treatment and ultimate eradication of the "white plague". Extravagant statements from high public health sources asserted that, because of these new drugs tuberculosis sanatoria could be closed, and expansion of tuberculosis treatment facilities was no longer necessary. Pictures appeared in national magazines showing tuberculosis patients dancing in hospital halls and empty beds vacated by erstwhile bedridden patients. Even television focussed its cameras on this new medical "miracle".

Such unbridled claims were immediately countered by more sober statements urging the medical and lay public to be more cautious and conservative, and to leave the evaluation of these new drugs to experts who have had years of experience in tuberculosis. *Time* magazine correctly paraphrased the feelings of the latter group when it said that miracle drugs come and go, but tuberculosis goes on and on.

It is appropriate to sum up the place of these new chemotherapeutic agents in tuberculosis. Turning to the original report,[1] it is seen that the authors noted a striking effect of these drugs on certain *systemic* manifestations of tuberculosis such as: reduction in fever, improved appetite and weight gain, reduction in amount and character of the sputum, and a strong antitussive action. In many cases the sputum showed a reduction in Gaffky count (a crude estimation of the number of acid fast bacilli per high power field). A few showed sputum conversion to negative, but only on direct unconcentrated smear. This cannot

1. Robitzek, E. H., Selikoff, I. J., and Ornstein, G. G.: Chemotherapy of Human Tuberculosis with Hydrazine Derivatives of Isonicotinic Acid. *The Quarterly Bulletin of Sea View Hospital,* 13:27 (January 1952).

be considered an adequate criterion for sputum conversion, as the National Tuberculosis Association defines negativity only when all means of isolation (including concentrated smear and culture of sputum and culture of gastric contents) have been negative on three successive occasions. Furthermore, the fundamental anatomic alterations of the disease, the destruction of pulmonary tissue with cavity formation, was not materially corrected. The patients still had open cavitation and caseous disease.

If confirmed, the new drugs, then, can be said to exert a strong systemic effect, and to reverse the acute, exudative lesions, but they have little or no effect on the destructive features of the disease. On page 340 of this issue is a report that the beneficial systemic effects cannot be duplicated, even with the same and greater dosages than those used at Sea View.

Further reading of the original report reveals that these patients were treated for a very short and insufficient time. The first clinical trial was started on October 2, 1951. Tuberculosis, however, is a chronic disease of many years' duration, and requires months and years of treatment and observation before therapeutic measures can be evaluated adequately.

No studies on bacterial resistance are reported. Although the drugs are apparently free of acute toxic effects, chronic toxicity studies are likewise not reported.

What conclusions can be drawn from these preliminary clinical trials? The first, and most important, is that no conclusion of the ultimate value of these drugs can be reached until a much longer period of study has elapsed, and until the initial benefits have been confirmed by other workers. Further investigations are needed on optimal dosage, duration of therapy, emergence of drug-resistant organisms, relapse after initial improvement, and the relation of this therapy to bed rest treatment. In addition, the place of these new preparations in preparing patients for collapse therapy or surgery requires evaluation. The American Trudeau Society, in a *News Letter* dated March 5, 1952, has summarized the problems that have arisen in connection with these new drugs, and points out that toxic reactions consisting of constipation, difficulty in starting urination, positional hypotension, dizziness, and eosinophilia have been noted. More important has been the slight drop in hemoglobin, and the presence of occasional casts and traces of albumen and reducing substances in the urine, which may indicate a nephrotoxic activity.

Much further study and investigation are required as well as research unhampered by unhappy and sensational publicity, so that an accurate appraisal of these new compounds can be made. Meanwhile, standard measures of tuberculosis detection and treatment must not be abandoned until the isonicotinic acid hydrazides have proved their worth.

In this connection, attention is directed to the timely articles which appear on pages 340, 361 and 375 of this JOURNAL. Dr. Willner's paper on slums and tuberculosis (page 361) reminds us that the disease has social as well as biologic components, and that cure by drugs alone is unlikely to be realized so long as a pathogenic social environment exists. The article from the Newark City Hospital (page 340) is, in some respects, a pioneer work representing one of the earliest definitive clinical studies of isonicotinic acid hydrazide yet reported.

ORIGINAL ARTICLES

ALLERGIC REACTIONS IN TREATMENT OF VARICOSE VEINS

Stuart Z. Hawkes, M.D.,* Newark, N. J.

The injection treatment of varicose veins is now administered to many types of patients by many different groups of our profession. It is carried out by general practitioners as well as by physicians in several specialties.

Reactions to solutions injected have been reported from time to time. Some of these are mild but others are severe. Some deaths are recorded. Occasionally the reaction occurs after the first few treatments, but it develops more commonly after a number of injections, or during a later course of treatment. In one large clinic, the incidence of these reactions was reported[1] as approximately 3 per cent. In the patients analyzed here the incidence was twice as high. Thirty-two of the 565 cases studied (approximately 6 per cent) experienced manifestations of allergy. It is therefore important to re-emphasize this problem. It is also well to consider premonitory symptoms and preventive measures.

CAUSE OF REACTION

Certain people are sensitive to quinine derivatives. For some time, care has been taken to avoid this drug in treating such individuals. Some people react to other basic substances and related drugs. When other therapeutic solutions were introduced for the injection of varicose veins it was not recognized at first that such drugs could also produce allergy. Evidence now exists that reactions have occurred following the administration of every known sclerosing agent. Some patients are sensitive to several different solutions. Merely changing to another solution is not sufficient. One must get away from the basic radicle or molecule.

Some authors have considered a history of sensitivity to other specific proteins of importance not only in determining the cause of these reactions but as a warning. However, only two instances were found in this study of a history of previous response to other foreign proteins.

The cause of the reactions has never been fully explained or understood. There are several valid theories. Tuft[2] states that drug allergy can be differentiated into (a) the natural hereditary or atopic type and (b) the acquired, induced or artificial type.

(a) The hereditary allergy or idiosyncrasy refers to a condition of hypersensitiveness or allergy in which the administration of a medicinal substance (in a quantity non-toxic for the average individual) is followed by an unusual but characteristic reaction. This direct allergy would account for the allergy caused by quinine and other basic substances or related drugs. It should be distinguished from the inflammatory reactions of the skin or contact dermatitis caused by allergic reactions to drugs applied *locally*.

(b) The acquired type of drug allergy is more common. The patient's cells become sensitized to the specific drug injected. On subsequent administration even minute amounts of the drug (which has been previously well tolerated) produce a reaction, the manifestations appearing after the lapse of an interval or incubation period. Thus the initial introduction of the drug does not produce any symptoms, but after being repeated at intervals sensitization occurs. Further administration produces an "immediate attack", the allergic state then persisting or disappearing entirely.

Landsteiner[3] and his collaborators in the study of haptens have shown that certain chemical substances may combine with other molecules in the body when this substance is able to conjugate with the specific protein.

* Vascular Clinic, Presbyterian Hospital, Newark, New Jersey.

1. Praver, L. L., and Becker, S. W.: Journal of the Americal Medical Association, 104:997 (1935).
2. Tuft, Louis: *Clinical Allergy*. W. B. Saunders Co., Philadelphia (1937).
3. Landsteiner, Karl: *Specificity of Serological Reactions*, (Revised Edition), Harvard University Press, Cambridge (1945).

The combination forms a complex substance capable of producing specific reactions. The specificity of the complex allergy is independent of the body protein but is dependent on the properties of the smaller simpler constituents in sensitized tissue. The specific reaction can be elicited not only by the entire complex, but occasionally by a fraction which contains simple chemicals, or even by the chemical alone. Landsteiner[3] also showed that certain simple chemicals may produce both antibodies and sensitivity and may elicit reactions even without the necessary primary conjugation with larger molecules.

TYPES OF REACTION

Ritchie[4] in 1933 called attention to the three types of anaphylaxis which may occur: (a) Erythematous or urticarial manifestations of the skin. (b) Gastro-intestinal disturbances with abdominal pain and diarrhea appearing shortly after injection. (c) Cardiovascular collapse with cyanosis, pallor, low blood pressure and at times loss of consciousness. (d) Shelley[5] added a fourth, referring to cases where during treatment an itching, thickened red area appears in the skin over the veins. If the offending solution is stopped the reaction subsides, but if it is continued the dermatitis spreads quickly becoming a generalized weeping eczema. He also points out that group B of Ritchie is probably a mild form of group C which is in reality a nitroid reaction.

These reactions may be very severe. Levi[6] and Shelley[5] have both reported deaths. Shelley also states that three unreported deaths are on record in the office of the Medical Examiner of New York City. The Medical Examiner[7] of Essex County, New Jersey has no record of such a death.

PREVENTION OF REACTION

An occasional report appears of a reaction during, or immediately after, the first injection. Such cases are rare and the reactions usually mild. The more frequent story is that of reaction after previous treatments. A still more common history is its occurrence when later treatment is instituted.

At times, the reaction is mild enough to pass unnoticed; or the patient attributes it to some other bodily condition. It may occur after the patient leaves the doctor's office and be unrecognized. Careful questioning should always precede additional treatments. An added precaution is to insist that potential or suspected reactors remain in the office under observation for fifteen to twenty minutes following an injection. If a mild reaction is discovered and the offending solution discontinued a more severe reaction will be avoided. Some authors have erroneously stated that a change of solution will eliminate further trouble. This is not true as was shown in nine instances among the cases studied. In fact, two exhibited sensitivity to three different solutions. The preliminary intradermal testing of patients has also been suggested as a way of avoiding reactions. Traub and Swarts[8] state that the suspicious substance cannot be studied by the usual intradermal methods because it is irritating. The skin of normal people will react positively. Patch testing might discover some reaction-producing substances.

TREATMENT OF REACTION

Many reactions are mild and need no treatment. The patient may complain of slight itching, burning, or flushing, or of a feeling of slight weakness or tiredness. These sensations will pass off in a few minutes. If more severe, rest for a short period with the administration of half of a cubic centimeter of epinephrine (1 to 1000) which may be repeated after 15 minutes, will suffice.

The more acute reactions are medical emergencies. If the reaction is a cardiovascular one, death at times seems imminent. The patient quickly faints, the radial pulse is imperceptible, blood pressure is unobtainable and respirations are slow and labored. Sphincter control is often lost. The patient's clothing is loosened. Epinephrine (1 to 1000) is given at short intervals in large doses (½ to 1 cubic centimeter). Nikethamide[9] (1.5 cubic centi-

4. Ritchie, Alison: Transactions of the Edinburgh Obstetrical Society, 157 (1933).
5. Shelley, Harold J.: Journal of the American Medical Association, 112:1792 (1939).
6. Levi, David: The Injection Treatment of Varicose Veins, in Rolleston, Humphrey, and Monerieff, A. A.: *Practical Procedures*, London (1938). Eyre and Spottiswoode.
7. Personal Communication: Medical Examiner, Essex County.
8. Traub, Eugene F., and Swarts, William B., Jr.: New York State Journal of Medicine, 37:1506 (1937).
9. Nikethamide is a pyridine beta carboxylic acid diethyl amide.

meter) and caffein sodiobenzoate (7.5 grains) are administered at fifteen minute to half hour intervals depending upon the length and severity of the reaction. Oxygen is helpful. Two patients in acute collapse who were found on the street after leaving the office were taken to hospitals. Plasma was administered in one of these. In this case, the blood pressure did not approach normal for twelve hours after the offending injection.

Although no deaths have occurred in the cases under study, in several instances it has been considered a possibility. These severe reactions are very unnerving to follow. If once experienced, great care will be exercised in avoiding them in the future.

SUMMARY

Thirty-two instances of reactions of varying intensity have been experienced in the injection treatment of 565 cases of varicose veins. Only those undergoing a number of treatments or a later course of treatments have been included. Those who received only one or two injections have been omitted from the total. Reactions have occurred in slightly more than 6 per cent of those receiving prolonged injection treatment.

Of the thirty-two cases, 27 occurred in women and only 5 in men. This proportion of approximately 5 to 1 is higher than the average sex ratio incidence of varicose veins of 3 to 1. The significance of this fact is not understood.

CONCLUSIONS

1. Severe reactions to injected solutions occur in the treatment of varicose veins in approximately 6 per cent of individuals.

2. These may be due to either hereditary or acquired allergy. The latter is the more common.

3. When a reaction has occurred, shift away from related basic substances such as morrhuate, oleate, or monolate, as one of these solutions may give similar severe reactions without having been previously injected.

4. Lack of allergic history does not preclude trouble.

5. Intradermal skin testing is misleading. Patch testing is to be considered for further studies.

6. Constant care and alertness is required as severe reactions may occur without any milder warnings.

7. If a reaction occurs, treat it as a medical emergency. Have the necessary stimulants continuously at hand.

161 Roseville Avenue

ISONICOTINIC ACID IN TUBERCULOSIS *

PRELIMINARY REPORT: CLINICAL EXPERIENCES

Elliot Witkind, M.D., Irving Willner, M.D., and
Otto Brandman, M.D., Newark, N. J.

Chemotherapy has altered the prognosis and treatment of tuberculosis. Streptomycin and para-amino salicylic acid (P.A.S.) have shown remarkable results, but the usefulness of these two drugs has been limited by their side reactions, including vertigo and other nervous system symptoms. Streptomycin and P.A.S. have stimulated the development of drug-resistant strains of bacilli. P.A.S., in large doses, may be very irritating to the gastrointestinal tract.

Hydrazides of isonicotinic acid have recently been studied both in the laboratory and in the wards. These drugs are reported to have bacteriostatic and bacteriocidal effects *in vivo* and have produced dramatic clearing of tuberculous lesions in experimental animals.[1] Preliminary studies[2] suggest that these hydrazides

* This work is from the Tuberculosis Service and from the Department of Medicine of the Newark (N.J.) City Hospital. The isonicotinic acid used was in the form Rimifon, the Hoffmann-LaRoche tradename for this drug. Rimifon was supplied through the courtesy of Dr. Leo Pirk of Hoffmann-LaRoche Company, Nutley, N. J.

have beneficial effects in patients mortally ill with far advanced tuberculosis.

This report is limited to an evaluation of isonicotinic acid hydrazide in the brand tradenamed Rimifon.[3] Twenty patients critically ill with advanced tuberculosis were studied for from 5 to 15 weeks (average was 12 weeks) with isonicotinic acid hydrazide as the sole therapeutic agent. Dose was 1 to 2 milligrams per kilogram of body weight during the first 6 days of therapy: and from 4 to 5 milligrams per kilogram therafter. The drug was given orally after meals.

Laboratory studies and chest roentgenograms were done at weekly intervals for the first six weeks and later semi-monthly. Careful weight records, temperature records and sputum studies were performed at frequent or daily intervals.

The results of this study were divided into systemic and local responses.

Systemic Responses: The appetite improved in 18 cases and was not improved in 2. Most marked improvement occurred in the first 3 weeks of treatment and lessened by the 7th week. Only one patient developed a tremendous appetite.

An increase in energy and sense of well-being was observed within a week to ten days and in general paralleled the lowering of the temperature levels. Night sweats decreased in 55 per cent of treated patients. The temperatures decreased slowly and took from 4 to 5 weeks before normal levels were obtained in 16 febrile cases. No precipitous drops were observed.

Frequent low grade temperature elevations from 100.5 to 101 were noted in several cases after an apparent return to normal levels. Seventeen patients gained an average of 9.6 pounds during courses of therapy (average 12.3 weeks). This gain was maximum in the third and fourth week of therapy. Three patients lost an average of 6.4 pounds during 8.2 weeks of therapy.

Local Responses: Between the 6th and the 10th week of treatment the cough disappeared completely in three patients, improved in 13, did not improve in 1 and became more severe in 3. The daily 24 hour sputum collection showed no change of sputum weight with persistent copious amounts of sputum in 16 and a decrease in sputum weight in only four patients.

Sputum conversion was observed in only one questionable case of pulmonary tuberculosis. The remainder of the group still had consistently positive sputum cultures. Sporadic rises in the Gaffky count were observed as late as the 10th and 15th week of treatment after the initial drops of tubercle bacilli count in the early part of our studies in two patients. The most dramatic response was observed in two patients with draining chest sinuses in whom good healing was observed by the 2nd week of treatment with Rimifon after a previous failure in one with nine weeks' course of streptomycin and P.A.S.

Serial roentgenograms showed that dramatic x-ray changes as evidenced by clearing of exudation and the diminution or closure of cavities did not occur during the period of treatment. Of 10 patients observed for a 3-month period, 5 patients showed some minimal improvement as evidenced by diminution of exudate. There was decrease in the size of the cardiac shadow in one patient with tuberculous pericarditis after 11 to 15 weeks of treatment. All patients with some improvement of x-ray findings still have positive sputa.

No serious untoward side reactions were observed in this study necessitating discontinuance of the drug. The majority of side reactions occurred during the first two weeks of therapy, e.g. dizziness, muscular tremor, spots before eyes, blushing, nausea, constipation and pruritis.

Up until the present time, no serious toxic reactions have been observed[4] in humans. However, our study indicates that this drug may have a hepatotoxic effect in man as evidenced by the development of a one to three

1. Grunberg, E., and Schnizter, R.: Quarterly Bulletin of the Sea View Hospital, 13:3 (January 1952); *and* Bernstein, L. *et al.:* American Review of Tuberculosis, 65:357 (April 1952); *and* Steenken, W. J., and Wolinsky, E.: American Review of Tuberculosis, 65:365 (April 1952); *and* Zieper, I., and Lewis, R. A.: Quarterly Bulletin of the Sea View Hospital, 13:12 (January 1952).
2. Robitzek, E., Selikoff, I., and Ornstein, G.: Quarterly Bulletin of the Sea View Hospital, 13:27 (January 1952).
3. Rimifon is the Hoffmann-LaRoche tradename for their brand of isonicotinic acid hydrazide.
4. Elmendorf, D. F. *et al.:* American Review of Tuberculosis, 65:429 (April 1952).

plus response to the cephalin flocculation test in six patients who had a negative reaction prior to treatment. Although moderate eosinophilia occurred, no toxic manifestations relating to the hematopoietic system were observed.

These preliminary observations indicate that isonicotinic acid hydrazide *does* exert an anti-tuberculous effect in humans. This manifests itself primarily against the systemic toxicity and to a much lesser extent against the local lesions observed in tuberculosis. One of the greatest assets of this preparation appears to be its ability to increase the appetite and subsequently the caloric intake and weight.

The greatest limiting factor to anti-microbial therapy in tuberculosis has been the development of resistant strains of tubercle bacilli. A recent report[5] indicates that bacterial resistance developed in three of six patients after seven weeks of treatment and in one the first indication of increased resistance was apparent in 26 days. These investigators also noted an initial fall in the Gaffky of these three patients followed by a rise at a time corresponding closely to the onset of bacillary resistance. We have also observed sporadic rises of the bacterial count as late as the 10th and 15th week of treatment after initial drops of the count in the early part of our study in two patients. The development of bacterial resistance may account for the high incidence of persistently positive sputa in this series; however, the number of cases and limited time did not permit us to reach any definite conclusions in this respect.

Our previous observations in a comparable group of patients treated with streptomycin and P.A.S. seemed to indicate that *more rapid resolution of exudative lesions occurred with these drugs than with isonicotinic acid hydrazides.* It was therefore decided to utilize Rimifon[3] in combination with streptomycin in six cases and with the addition of P.A.S. in two moribund patients. Results to date seem to justify the combined use of these preparations, especially in those patients with severe anorexia or gastro-intestinal upsets resulting from the use of P.A.S. alone.

The development of chemotherapy in tuberculosis has in no way altered the indications for pneumothorax or other surgical procedures. At present no single preparation can be relied on to cure tuberculosis. However, the judicious use of Rimifon[3] in combination with streptomycin and/or P.A.S. may act in a synergistic manner and prove superior to any single preparation or previous combinations.

5. Steenken, W. J. *et al.:* Journal of the American Medical Association, 149:187 (May 10, 1952).

SUMMARY

1. Twenty patients with tuberculosis have been treated for 5 to 15 weeks with isonicotinic acid hydrazide, with no other therapeutic measures.

2. Systemic manifestations of tuberculosis (such as appetite, energy, night sweats, temperature, and weight) appeared to be favorably influenced by the drug. Cough was decreased in most patients; but 24 hour expectoration was lessened in only four cases. Sputum conversion occurred in only one instance; the remainder of the group have had persistently positive sputa despite continued therapy. The possibility of development of bacterial resistance as evidenced by a late rise in the Gaffky count in two patients is emphasized.

3. Serial roentgenograms showed minimal diminution of exudation in only five cases; but positive sputa still persisted in these patients.

4. The toxicity and "side-reactions" of the drug are described and suggestive evidence of a hepato-toxic effect in humans is discussed.

5. The possibility of synergism beween isonicotinic acid hydrazide, streptomycin and P.A.S. is stressed and preliminary favorable observations are presented.

116 Fairmount Avenue

MESENTERIC THROMBOSIS WITH SURVIVAL

A. G. MERENDINO, M.D., Atlantic City, N. J.

A case of mesenteric thrombosis with survival is here reported to emphasize (a) the rarity of pre-operative diagnosis, (b) the post-operative complications, and (c) the significant symptoms and history.

A 50-year old woman complained of vomiting, abdominal pain of a colicky nature, and several episodes of diarrhea. These symptoms had been present for three days prior to admission to the hospital. One week before these symptoms appeared, she had had a similar attack, and had been briefly hospitalized. She had then been told that she was suffering from a "nervous breakdown" resulting from the sudden death of her husband. She had been advised to come to Atlantic City to recuperate. Her complaints recurred soon after arrival.

She was an obese, pale, woman, groaning from severe abdominal pain. Periodically the pain would subside and recur. Heart and lungs were normal. Blood pressure was 100/80. Abdomen was distended and rigid, with maximum point of tenderness and rigidity in the right lower quadrant. Vaginal examination was negative. The temperature was 100 and the pulse was 96. Her lower extremities did not reveal any abnormality. On admission her red blood count was 4,040,000; white count was 17,150; hemoglobin 79 per cent; polys 85 per cent; lymphocytes 13 per cent; basophiles 2 per cent. Urinalysis was negative. Pre-operative diagnosis was acute appendicitis.

A lower right rectus incision was made. On opening the peritoneal cavity, a quantity of serosanguineous fluid exuded. The exudate was suctioned out and the pathology present was very obvious. Matted together with a thick exudate, 12 inches of small bowel were markedly gangrenous. The corresponding mesentery was doughy and the veins appeared as black, thrombosed vessels and felt like cords. A resection of 22 inches of bowel was performed taking 5 inches of normal bowel on each side of the gangrenous portions. A side-to-side anastomosis completed the operative procedure. Two pints of blood were given by transfusion during the course of the operation.

Antibiotics and parenteral fluids were then given daily. A Levine tube was placed into the stomach and attached to a Wangensteen apparatus. The patient was responding very well. The sutures were removed on the 8th postoperative day. On the tenth postoperative day she complained of pain in her right leg. On the eleventh day, the leg was edematous. A diagnosis of thrombophlebitis was made and anti-coagulant therapy was considered. Initial prothrombin activity test showed 100 per cent. Dicumarol[1] was begun, with 300 milligrams the first day, 200 the second day and 100 milligrams on the third day. The patient experienced sudden soreness in her incision on the third day of anti-coagulant therapy. Inspection showed a huge hematoma of the abdominal wall adjacent to the line of incision. Daily prothrombin tests had been done and the lowest reading was 55 per cent. The Dicumarol[1] was immediately stopped; a 500 cubic centimeter blood transfusion was given, and vitamin K started intravenously. The edema and pain in the right leg soon subsided. Three days later, she suddenly developed swelling and pain in her left lower extremity, the edema reaching her inguinal fold. It was obvious that she had developed a thrombophlebitis in her left leg. Treatment continued along conservative lines with no further anti-coagulant therapy. The hematoma of the abdominal wall soon became a necrotic area that sloughed out producing a defect about the size of an orange down to the fascia. The patient was then brought back to the operating room, for excision of the necrotic area and plastic repair. Three days later she was transported by plane to her home town hospital where she finally and fully recovered.

This case of mesenteric vascular occlusion was venous in contrast to arterial. The effects of venous thrombosis are less severe and less extensive than those of arterial blockage. Meagre symptoms of mild colicky abdominal pain with repeated attacks of diarrhea may be present for days[2] without suggesting anything as serious as mesenteric thrombosis. This patient had been hospitalized for one week and a diagnosis of "nervous breakdown" was made. It is possible that she had mesenteric thrombosis during that hospitalization and she recovered because of the rich collateral circulation of the bowel.

Review of the literature reveals the rarity with which a pre-operative diagnosis of mesenteric thrombosis is made. In most instances, the diagnosis is impossible because the symptoms are mild, slow and deceptive. In retrospect the symptoms and signs in this patient coincided with the operative findings.

Despite the precautions taken while instituting anti-coagulant therapy, this patient developed bleeding in her abdominal wall. This serves to emphasize the care that should be exercised in the use of the anti-coagulants.

1. Collective registered trade-name, Wisconsin Alumni Research Foundation.

2. Maingot, Rodney: *Abdominal Operations*. Ed. 2. Appleton Century Crofts, Inc., New York, 1948, page 963.

SUMMARY

1. Pre-operative diagnosis of mesenteric vascular occlusion of the venous type is rare and, in most instances, impossible.

2. Extreme care should be exercised in anti-coagulant therapy.

3. Symptoms and signs may be slow, and meagre and pursue a course of many days before a surgical emergency is established.

1616 Pacific Avenue

DEPO-HEPARIN* FOR LONG TERM THERAPY OF MYOCARDIAL INFARCTION

Irvin Sussman, M.D., Bridgeton, N. J., and
Ernest Lydecker, M.D., Jersey City, N. J.

The efficacy of anti-coagulant therapy in reducing the morbidity and mortality from thrombo-embolic complications in myocardial infarction is well established.[1] Most large hospitals routinely gave Dicumarol[2] or Tromexan[3] to patients with coronary thrombosis and regulate dosage by obtaining a daily prothrombin time.

These substances are not readily adaptable to the small hospital where myocardial infarction is treated only occasionally, or where accurate prothrombin times cannot be consistently obtained. The availability of Depo-Heparin* and the demonstration of its value in peripheral vascular disease[4] and short term use in myocardial infarction suggests that it might be used for long term therapy of myocardial infarction without need for additional laboratory facilities and without the clinical dangers associated with Dicumarol[2] and Tromexan.[3] The observation of the effectiveness of heparin in changing lipoprotein patterns[5] also makes its clinical trial in coronary thrombosis desirable.

Use of heparin in a retarding menstrum in twenty cases of coronary artery thrombosis has been reported[6] with favorable results. This study indicated the advantages of simple laboratory control, prompt anti-coagulant response and absence of hemorrhagic complications.

This is a report of twenty cases of coronary thrombosis treated with Depo-Heparin* in three small hospitals with bed capacities of less than one hundred beds, and in one large medical center.

MATERIALS AND METHODS

Fourteen patients were studied in the Bridgeton, Elmer and Millville Hospitals and six in the Jersey City Medical Center. Each patient had clinical features and electrocardiographic changes characteristic of acute myocardial infarction.

On hospitalization, initial studies included an electrocardiogram, clotting time, complete blood count, sedimentation rate, blood sugar and blood cholesterol. Clotting times were obtained every twelve hours. Depo-Heparin* (without vasoconstrictors) was administered intramuscularly in dosage of 200 milligrams each time the clotting time fell below twenty minutes. Therapy with Depo-Heparin* was continued until the patient was ambulatory.

OBSERVATIONS

Ages varied from 31 to 72. Five were female and fifteen were male. Associated diseases included hypertension in 5 patients, chronic glomerular nephritis in one patient and emphysema in one patient. Twelve had anterior wall infarctions, six had posterior wall infarctions and in one the infarction involved both the anterior and posterior wall. (See the table.)

As reported by other observers,[4,7] we also noted great individual variations in the reaction to Depo-Heparin* and varied reactions

* Depo-Heparin is a combination of heparin sodium, gelatin and dextrose, trade-named by the Upjohn Company. Dr. H. F. Hailman of that Company kindly furnished the supply of Depo-Heparin used in this study.

in the same patient from day to day. The marked fluctuations of the clotting times did not appear to have any effect on the clinical course of these patients. The average dose of Depo-Heparin* was 200 milligrams every twenty-four hours. There was a variable response, however, and it was found desirable to obtain clotting times at least every twelve hours during the first week of therapy. None of the patients had a bleeding tendency. There was little change in the total serum cholesterol with therapy. Serial sedimentation rates showed a progressive decrease with improvement of the myocardial injury.

Clinical manifestations of extension of the myocardial infarction were noted in three patients. None of these were fatal. The following case history is illustrative:

1. A 50 year old white male was admitted to the Bridgeton Hospital with complaints of edema, shortness of breath and orthopnea. A year earlier he had been treated for a coronary occlusion at which time he was found to have hypertension. Physical examination on admission revealed dyspnea, orthopnea and cyanosis. His left cardiac border was percussed in the anterior axillary line. A grade three systolic murmur was heard at the apex. Liver was enlarged three fingers below the right costal margin and was tender. There was two plus edema of the legs up to the knees. Chest x-ray revealed an enlarged cardiac shadow and on fluoroscopy there was very little pulsation of the left ventricular border.

An electrocardiogram showed typical changes of recent anterior infarction. Sedimentation rate was 25 millimeters in one hour. Urinalysis was negative. Complete blood count, blood sugar and serologic tests for syphilis were all normal. Depo-Heparin* was instituted and continued for 60 days. On the 19th hospital day, his heart sounds were muffled and blood pressure dropped to 114/80 from an initial pressure of 150/100. Electrocardiogram at this time showed evidence of extension of the area of infarction. This was associated with a pericardial friction rub and an increase in sedimentation rate. Subsequent examination of the patient with chest x-ray and electrocardiogram revealed signs of ventricular aneurysm. One year later the patient returned to his business and is presently leading a relatively normal life.

The drug had to be stopped in one patient because of nausea and vomiting after each injection. Whether this was related to the chemical constitution of Depo-Heparin* or the psychic trauma was not clear.

7. A 64 year old white male was admitted to Millville Hospital because of severe chest pain on the evening before admission. He had a past history of angina and dyspnea on exertion. Physical examination revealed a blood pressure of 140/100 and moist rales at both lung bases.

Electrocardiogram was consistent with an acute anterior myocardial infarction. On his eleventh hospital day, the patient began to have nausea and vomiting following each injection of Depo-Heparin.* The drug was discontinued and the nausea and vomiting stopped.

In two patients, both physicians (not included in this series) the drug could not be used after two or three injections because of severe pain associated with injection. Two patients complained of mild pain, but continued to take the drug.

The presence of clinical renal abnormalities in two of the patients did not appear to alter the tolerance or response to Depo-Heparin.*

5. A 34 year old white male was admitted to the Bridgeton Hospital with a history of severe chest pain and dyspnea the preceding evening. On admission, blood pressure was 130/104. A pleural friction rub was heard over the left lung base. Signs of consolidation were present over the lower left lung. A gallop rhythm was present.

Electrocardiogram showed extensive anterior myocardial infarction. The patient was admitted with a temperature of 101 which progressively rose to levels between 104 and 106 on the fifth, sixth and seventh hospital day. Terminally, he developed uremia and died on the seventh hospital day. He apparently had a massive pulmonary infarction on admission and Depo-Heparin* therapy did not alter the clinical progressive, downhill course. Even in the presence of uremia, the patient maintained a marked tolerance to Depo-Heparin.* The patient in our case 4 also had chronic glomerulonephritis. Her response to Depo-Heparin* did not differ significantly from that of other patients in this group.

1. Wright, I. S., Marple, C. D., and Beck, D. F.: The Journal of the American Medical Association, 138:1074 (1948); also Wright, I. S., Marple, C. D., and Beck, D. F.: American Heart Journal, 36:801 (1948); also Editorial: Annals of Internal Medicine, 30:436 (1949). Marple, C. D.: American Practitioner, 2:393 (1951).

2. Dicumarol is bishydroxy coumarin, and the word "Dicumarol" is the collective registered trademark of the Wisconsin Alumni Research Foundation.

3. Tromexan is a brand of ethyl biscoumacetate trademarked by the Pharmaceutical Division of the Geigy Company, Inc.

4. Crane, C.: New England Medical Journal, 245:926 (1951).

5. Jones, Hardin B., Gofman, J. W., Lindgren, F. T., Lyon, T. P., Gramham, D. M., Strisower, Beverly and Nichols, Alex V.: American Journal of Medicine, 11:358 (1951).

6. Loewe, L., and Eiber, H. B.: American Heart Journal, 37:701 (1949).

7. Glueck, H. I., Popore, C. J., and Levinson, J. E.: Circulation, 2:530 (1950).

8. NOTES: Patient 1 had coronary thrombosis a year prior to current episode. The marked renal disease in case 4 did not affect tolerance to Depo-Heparin.* In case 7 it was necessary to stop the Depo-Heparin* because of vomiting. Patient 9 had had a myocardial infarction 1½ years prior to present episode. Patient 10 was in oxygen for 3 weeks and had had an episode of pulmonary infarction. Moderate liver dysfunction was present in case 12. He was well maintained with daily injections of Depo-Heparin.*

SUMMARY

A study of 20 patients indicates Depo-Heparin* is an easily available preparation for anti-coagulant therapy in myocardial infarction. It has the advantage of prompt effectiveness, ease of administration, lack of significant complications and simplicity of laboratory measures for control. This mode of anti-coagulant therapy is available to patients with myocardial infarction in smaller hospitals and in the home.

Appreciation is expressed to Dr. Carroll M. Leevy, Director of Clinical Investigation, Jersey City Medical Center for his many helpful suggestions and comments.

Patient	Age	Associated Diseases	Electrocardiogram	Complications	Duration of Symptoms Before Depo-Heparin* Days	Depo-Heparin* Days	Depo-Heparin* Total Injections
1	50 M	Hypertension	Anterior infarction	Ventricular Aneurysm Congestive failure[8]	2	39	46
2	69 F	Hypertension	Left bundle branch block Complete heart block Multifocal extra systoles	Stokes-Adams seizures	1	27	23
3	75 M	None	Anterior infarction	None	6	16	21
4	31 F	Chronic Glomerulo-nephritis	Anterior infarction	None[8]	2	32	32
5	34 M	None	Anterior infarction	Massive infarction Pneumonia	2	7	10
6	55 M	None	Anterior infarction	None	1	28	28
7	65 M	Hypertension	Anterior infarction	Homonomous hemianopsia[8]	1	14	19
8	72 M	Hypertension	Antero-septal infarction	None	3	26	25
9	38 M	None	Recent antero-lateral infarction	None[8]	¼	27	24
10	66 M	None	Antero-posterior infarction	Hemoptysis[8]	¼	42	40
11	55 M	None	Postero-lateral infarction	None	½	29	32
12	43 M	None	Anterior infarction	None[8]	1	29	32
13	67 M	Emphysema	Antero-septal infarction	None	4	36	46
14	42 M	None	Posterior infarction	None	3	30	39
15	59 F	Hypochromic anemia	Posterior infarction	None	1	30	40
16	41 M	None	Posterior infarction	None	1	30	30
17	51 M	None	Posterior infarction	None	1	30	46
18	72 F	Hypertension	Posterior infarction	Broncho-pneumonia	3	25	23
19	49 M	None	Anterior infarction	None	6	32	32
20	67 M	None	Anterior infarction	None	4	42	39

8. See note 8 on botton of previous page.

151 West Commerce Street, Bridgeton, N. J.

Jersey City Medical Center, Jersey City, N. J.

DIABETIC NEUROPATHY *

Floyd Fortuin, M.D., and Hans Wassing, M.D., Paterson, N. J.

The incidence of neuropathy in diabetes is variously estimated at 49 per cent (Sevringhaus[1]) 50 per cent (Stewart[22]) 66 per cent, (Epstein[9]) to as little as 5 per cent. Estimates seem to vary with the completeness of examination and the criteria used. Terminology is not standardized, the terms neuritis (or polyneuritis) and neuropathy being used interchangeably to a large extent. Rundles[2] has sought to bring some order into the chaos by defining "neuropathy" more precisely. He defines it as "peripheral nerve disease with symptoms and objective evidence of neurologic abnormality in which there is a predilection for involvement of small caliber neurons. The diagnosis of diabetic neuropathy should not be made unless evidence of disturbed nerve function persists well beyond any temporary period of nonregulation." Limiting it so sharply, Rundles[2] found neuropathy in only 5 per cent of three thousand diabetics. By such a definition he excludes a large group of transient "neuritides" and myalgias that are part of the acute picture associated with diabetic nonregulation and subside readily with control. It is to this group, which often merits a separate category, that Wechsler's comment "Diabetic neuropathy is rare; diabetic pains are common" is applicable.

To the usually recorded symptoms of pain, paresthesias, and dysesthesias of the extremities (lower extremities for the most part), we should like to add and stress the cranial nerve involvement and particularly the autonomic nervous system involvement to which Rundles[2] has devoted so much attention and study. Pain, usually severe, is variously described; and like the paresthesias is often worse at night interfering with sleep until discomfort passes with the early morning hours. The nocturnal character of the pain may be related to vasodilation and fall of blood pressure which is part of uninhibited activity of the parasympathetic nervous system.[3] These factors conceivably cause pain through oxygen deprivation in the attenuated overactively dilated vessels. This anoxia is further abetted by cardiorespiratory decrease in oxygen carriage during recumbency. Often only the soles of the feet are affected and we have been impressed particularly with two patients who described a "ballooned" feeling of the feet. Paralyses are not common; muscular weakness and atrophy less so. Cases of pseudo-tabes with ataxia as the chief symptom are well known. Of the less common paralyses, foot drop, ocular palsies (chiefly the 6th cranial but also the 3rd and 4th), varying grades of iridoplegia, and facial paralyses are not infrequently observed.[4] Reflexes generally are found unequal; the lower extremity reflexes may be sluggish to absent. In addition to the usual findings of nerve pressure tenderness and sensory alteration, attention has been directed by Collens *et al.*[5] to the early vibratory sense changes which can be estimated by holding a tuning fork on the index finger of the patient's hand and comparing his reaction time (when vibrations cease) to the examiner's own.

The autonomic nervous system derangement can be classified under visceral and vascular headings. The former includes sphincteric disturbances; anorexia; nausea; vomiting; diarrhea (often nocturnal); impotence; bladder irregularities; cardiac irregularities; abnormalities of sweating (night sweats) and alteration of responsiveness to heat and cold with much reduced tolerance. Under the "neuro-vascular" heading, first consideration should be given to the vasomotor changes in the lower extremities, independent of sclerotic factors contributing to perforating ulcers, Charcot joints, and possibly to peripheral asphyxia and gangrene. Rundles[2] speaks of orthostatic hypotension with symptoms of weakness, dizzy spells, syncope with standing, related to a drop of blood pressure of 50 millimeters or more on assuming the standing position from the supine. Also important are vascular changes in the eye grounds often including apparent hemorrhages,

* Read before the Section on Metabolism at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1952.

more exact knowledge of which has demonstrated pathognomonic venous aneurysms.

Several related neurologic entities often complicate the picture and change the prognosis. Early beri-beri might exactly simulate diabetic neuropathy clinically; and considering the advanced states of malnutrition in unrecognized, unattended diabetes, it might conceivably add its toll. The striking resemblance of diabetic neuropathy clinically and pathologically to ischemic neuritis has led many contemporary clinicians to regard the diabetic neuropathy mainly on that basis. This is due largely to the extensive work of Woltman and Wilder,[6] which, though now 23 years old, is still the point of departure for all subsequent study and research. In any case, it is important to make a careful examination of the arterial supply to the extremities; and if examination with clinical and laboratory study reveals sclerotic obstruction to the blood flow, it is not unreasonable to suspect involvement of the vasa nervorum, adding an unfavorable prognostic factor. Some classifications have included the latter group among the diabetic neuropathies. For example, Jordan[7] speaks of degenerative and circulatory types; Treusch[8] of an ischemic neuropathy; Epstein[9] of diabetic neuropathy with (or without) vascular sclerosis. We have felt it more sound to recognize the coexistence of ischemic neuropathy rather than represent it as a part of diabetic neuropathy, both entities existing apart from one another, despite their obvious close relationship. Alcoholic neuropathy may have much the same signs but the symptoms are less severe and less specific. Combined system disease must be carefully ruled out, actually appearing coincident with diabetic neuropathy in one of our cases and necessitating a careful differential diagnosis in another case. Although the paresthesias may parallel, pain is not a striking feature of subacute combined sclerosis; and pyramidal tract signs (as well as far more prominent signs of posterior column involvement) are superimposed on the not infrequent neuritic signs in combined system disease. Signs and symptoms of a heavy metal neuritis as well as early signs and symptoms of cord disease may need to be ruled out, the latter actually occurring in one of our cases as a diagnostic error.

Pathologic changes in the nerve in the "toxinutritional group" of neuropathies varies from swelling of the myelin sheath to complete degeneration of the nerve fiber with fragmentation of the myelin and of the axis cylinder, ingestion by phagocytes and proliferation of the sheath of Schwann. In this group of "toxinutritional neuropathies" the peripheral ramifications of the nerves in the distal portions of the extremities are initially involved (Lichtenstein[23]). With regard to estimating the degree of demyelinization, Rundles[2] adds a word of caution because diabetes mellitus, in contradistinction to pernicious anemia, affects primarily the small caliber, poorly myelinated neurons ("We would be looking for fibrils that were not there"). The anterior horn cells and the columns (posterior columns, mainly) of the spinal cord are rarely affected by the diabetic process. Minute hemorrhages into the nuclei of cranial nerves, (e.g. nuclei of the third nerve) have been postulated[10] to explain isolated cranial nerve palsies in diabetes, but this explanation does not seem satisfactory. In the group with associated or predominant vascular implication, one finds in addition to the nerve degeneration—and evidently partly responsible for the latter — sclerosis of the intraneural and perineural arterioles.

The spinal fluid may be entirely normal. Some cases of diabetic neuropathy (about 50 per cent), however, resemble closely the type of acute infectious polyneuronitis, showing albuminocytic dissociation in the spinal fluid (high protein, normal cell count—Guillain-Barré Syndrome). These cases seem to suggest some peculiar sensitization process (we purposely avoid the term "allergic") as the underlying pathophysiologic cause. In this connection, it does seem of interest that a number of the so-called degenerative or arteriosclerotic cases of diabetic "neuritis" also show increased spinal fluid protein with normal cell count in the spinal fluid, although in Epstein's cases,[9] as a whole, the group with sclerosis did not show as high protein values as did the group without sclerosis. We have wondered

whether some of the true diabetic neuropathies might not show protein elevation at a later date in the course of the disease, although in the first puncture normal values were found. We have found no studies to indicate follow-up with repeat punctures.

Woltman and Wilder[6] in 1929 described the pathologic changes in the peripheral nerve in diabetes mellitus and came to the conclusion that "the most significant lesions are associated in nearly all cases with marked thickening of the walls of the intraneural vessels" and "the factor of greatest significance to explain diabetic neuritis is atherosclerosis". This vascular or circulatory explanation of the pathologic features and functions in diabetic neuropathy has — with exceptions — remained a leading thought until recently; and, most recently again, the vascular theory has been emphasized, e.g. by Broch and Klövstad.[12] We want to quote the Editor's supplementary note following the abstract of Broch's and Klövstad's paper in the *1947 Year Book of Neurology and Psychiatry:* "Vascular disease is of first importance in the etiology of the neurologic complications of diabetes mellitus; arteriosclerotic changes in the vasa nervorum" are an explanation of the peripheral nerve changes in diabetic neuropathy "overlooked by many". Yet, a simple review of the age of the patients, who served for these conclusions speaks against a generalization of a vascular pathogenesis. Of the ten cases studied by Woltman and Wilder,[6] one was 49 years old, four were between 50 and 60, two between 60 and 70 and three were over 70 years of age. Among the patients studied by Broch and Klövstad,[12] 61 per cent were over 50 years of age (with the more severe forms of neuropathy occurring in the older age group). Diabetic neuropathy often occurs in young patients without circulatory abnormality; and severe arteriosclerosis in older diabetics is often *not* associated with neuritis. Evidently "toxinutritional" factors combine frequently with circulatory disorder (basic disturbances in the enzyme system of the peripheral nerve combine with ischemic disturbances) and "it may be that there is in persons in whom polyneuritis develops, regardless of the cause, a constitutional defect present in the enzyme system" (von Hagen[13]). The fact that "diabetic neuropathy is often completely reversible also is evidence that the typical case of acute diabetic neuropathy has nothing to do with arteriosclerosis" (Joslin[14]).

"Nerve lesions in diabetes mellitus do *not* depend on mere hyperglycemia and glycosuria or on the presence of ketone bodies. Little or no sugar may be present in the urine when nerve lesions become evident" (Wilson[4]). Wilson[4] emphasizes "nerve *lesion*" because there exists a "hyperglycemic neuritis" previously alluded to (Jordan[7]); this (Treusch's[8] "diabetes with pain") applies to pain and paresthesias seen in diabetics who are badly decompensated, in those with impending acidosis, and in youngsters with acute onset of diabetes. They disappear promptly, when the diabetes is put under control.

Rundles[2] emphasizes that the "therapeutic experience confirms the diabetic etiology of diabetic neuropathy and that successful treatment of diabetic neuropathy requires meticulous diabetic regulation while no other type of therapy has been of definite value, implying a definite relationship to the natural history of diabetes". He evidently refers to the "intensely complicated biochemical system involving glycolysis and all the related ancillary factors" (Handelsman[24]) and to Wilson's[4] thesis, "Due to pancreatic insufficiency or independent of same, metabolic changes might occur that give rise to some incompletely resolved toxic product which, via the circulation, reaches the peripheral nerve and so starts the degenerative process." Rundles[2] says, "I am not surprised that the cause of diabetic neuropathy in metabolic or chemical terms has not been discovered. The same can be said of all the complications resulting from chronic insulin deficiency with its under-utilization of carbohydrates, excessive mobilization of fats and breakdown of proteins."

Diabetic neuropathy usually develops in cases of longer or shorter nonregulation of the diabetes. While in a homogeneous group of diabetics, the patients with neuritic involvement have, on an average, higher blood sugar levels than those without neuropathy (Bonkalo[15])—the hyperglycemia *per se* will not

cause "nerve lesions". While regulation of the diabetes seems, to date, to be the most important curative factor in diabetic neuropathy, it is not the establishment of a normal blood sugar *per se* that is the curative principle. Of course, the clinician will be guided by the response of the blood sugar value in his therapeutic efforts. However, he will not have much success if he does not watch for various additional features which will be discussed under the paragraph dealing with therapy. In Joslin's series[14] of fifty cases of diabetic neuritis (he excludes all cases of "ischemic" neuropathy), the average duration of the diabetes was six years. There are patients in whom the neuropathy was the first evidence of diabetes. In these cases, the question of how long the diabetes existed before its discovery, when the neuritic involvement appeared remains open.

The most important factor in treatment is prompt and proper attention to the diabetes including control of diet adjusted in calories, carbohydrates, fat, and protein as well as by insulin. Most cases respond favorably. It is not infrequent, however, to have signs and symptoms of diabetic neuropathy and even pellagra first appear or become aggravated with diabetic treatment. Unfortunately follow-up statistics are lacking in all reports, except for the consistent comment that "the majority" of cases of diabetic neuropathy do well under proper management of the diabetes often requiring several months to clear. Proper follow-up studies would have to include analysis of the duration of symptoms as well as incidence of eventual recovery and also add an analysis of cases with unfavorable complications. These complications, as for example, obliterating sclerosis, trophic ulcers, bone changes, and long duration of uncontrolled diabetes, are generally indices of poor prognosis.

In the main, vitamin therapy has been of no help. Collens *et al.*[5] produced some impressive graphs of improvement with massive doses of vitamins with objective relief obtained in 60 per cent, subjective relief in 72 per cent. Personally, we were not impressed with their results and believe that significant results would include earlier improvement over and against a control group. In 1952 the same authors[16] published a paper in which they concede that their prior results were not too significant. Root[17] in 1922 was the first to suggest vitamin deficiency as a factor in diabetic neuropathy. Joliffe[18] and co-workers postulated diabetic neuropathy to be due to vitamin B-1 deficiency after analyzing the deficient diet of nine neuritic cases assuming that the associated vascular inadequacy, the loss of vitamin B-1 through polyuria, the disturbed metabolism interfering with proper utilization of vitamin B-1, and finally the increased need for thiamin when through establishment of insulin therapy an increased utilization of carbohydrates takes place—all necessitated extra vitamin B-1 administration. Sydenstricker[25] likewise believed that better utilization of carbohydrates, stimulated by insulin therapy led to increased need for thiamin and other vitamins as coenzymes, thus creating a vitamin deficiency to the general organism. Subsequent extensive therapeutic administrations of vitamin B-1 have failed to confirm their tenets. Others have assumed that perhaps there are still unknown vitamin factors in crude liver that might be efficacious and Collens *et al.*[11] have been experimenting with pregnant mammalian liver extract obtaining significant alleviation of all symptoms in approximately seven days in 84 per cent of 127 patients without dietary or insulin treatment. One investigator, Rabinowitch[19] has largely confirmed their results. Some authorities make mention of the negligible amounts of vitamin B-12 in their product while other investigators make high claims for prompt relief of symptoms with vitamin B-12 —and so the contentious claims continue. Sheridan and Bailey[21] found that crude liver extract was almost a specific for the obstinate, distressing symptoms of nocturnal intermittent diarrhea in diabetes.

Psychological factors are of prime importance, particularly with respect to dietary irregularities, which are often protests against the physician's handling of his case or against the interference of parental (familial) figures.

CASE ONE

Acute diabetic neuropathy with Guillain-Barré type of spinal fluid changes and sensory dissocia-

tion of the lower extremities leading to a tentative diagnosis of syringomyelia by a qualified internist. Recovery was accomplished in six months but the patient still retained residuals of absent tendon reflexes in the legs and sensory diminution below the knee.

This 42 year old male physical training teacher with a history of weight loss of nine months' duration, was discovered to have diabetes (brother similarly affected) three months before his present illness. He developed a burn on both lower legs from a hot water bottle. Marked diminution of sensibility for pin-pricks and for temperature in a "stocking" area was found by his internist. The patient was hospitalized with a tentative diagnosis of syringomyelia (independent of his diabetes). At about that time he started to complain of rapidly increasing burning pain in the soles of the feet, more severe at night, and of a very distressing "ballooned feeling" of the toes. In addition to the pains in the legs he developed shooting and gnawing pains in the jaws which were present at rest, became worse on eating (chewing). He complained of generalized discomfort and pains "all over". Vibratory sense, position sense and superficial touch sensation were essentially normal. The disturbance of pain and temperature sensation was marked up to the knees, moderate up to the hips. There was generalized motor weakness, but there were no actual paralyses or pareses. Deep tendon reflexes of the legs were absent. Typical diabetic retinitis was found. Fasting blood sugar was 190 and the urine showed a three plus sugar, no acetone. Spinal fluid was under normal pressure; spinal fluid protein was 132. With diet, insulin, and small amounts of vitamin B-complex there was slow but steady improvement. Six months after the onset of the neurologic symptoms, he felt fairly well, and after another few months he was free of pain and had regained most of his former weight and strength. He was last examined six years after the onset of the neuropathy, and said that he feels perfectly well. Whitish, shiny, irregular small patches in the retina were seen in the right eye. Deep tendon reflexes were absent in both legs. Vibration sense was slightly diminished in the ankle region, pain and temperature sense prompt in both legs; but there still is a slight diminution of these two sensory functions below the knee, when compared with temperature and pain sensation above the knee.

CASE TWO

Acute diabetic neuropathy with bilateral sensory and motor involvement but with normal spinal fluid protein.

This 47 year old male factory worker was in good health up to two months before examination. He became badly chilled after many hours' exposure to icy waters while engaged in rescue work during a flood. Two weeks later he noted paresthesias of both feet followed in one week by weakness of the legs and then paresthesias of the fingers and weakness of the hands, more marked on the left. No actual pain was noted but the paresthesias were very distressing and he too complained of "ballooned" feeling in the toes. One brother is a diabetic. Examination disclosed weakness of both legs, especially of the extensors of the feet (foot-drop). Tendon reflexes were diminished in the upper extremities and absent in the lower. While the plantar response was normal, we were not able to elicit any of the abdominal or cremasteric reflexes. Position sense was poor in the toes of both feet; vibration sense poor or almost missing up to the hips, prompt in the upper extremities; dysesthesia with hyperpathia for pinpricks in the fingers and toes.

The urine showed a trace of sugar; the blood sugar was 143. Sugar tolerance test was typical of diabetes mellitus. The spinal fluid was entirely normal in every respect (the protein was a low-normal and globulin was negative). Though this was evidently a mild diabetes the patient was put on insulin in view of the severe neuropathy, was kept on a fairly liberal diet, received large amounts of thiamin chloride and B-complex by mouth, and also intramuscular injections of vitamin B-complex.

Recovery was very slow. The foot drop and the distressing paresthesias were stubborn. Nine months after onset of the neuropathy, he was able to return to a job which involved climbing ladders. He has retained to date, however, (two years after onset) some residuals, including slight extensor weakness of the feet and paresthesias of "stocking" distribution in both feet, reaching up to the tarsus. The knee jerks have returned (brisk on the right, sluggish on the left); the Achilles reflex is absent bilaterally. Position sense is prompt; vibratory sense has returned but is still somewhat diminished up to the ankles. The diabetes is very well controlled.

This man was placed on vitamin B-12. Its effectiveness was dubious.

From the reports of Collens *et al.*,[11] pregnant mammalian liver extract would have been indicated in this case. These first two cases definitely militate against the implication of Joslin, Epstein and others that a direct correlation exists "between severity of the neurologic disturbance and the higher total protein values in the spinal fluid". In our second case the protein was a low normal, yet, the neurologic disturbance very severe.

CASE THREE

Superior rectus palsy due to diabetic neuropathy.

This 37 year old female factory worker, was in good health up to five weeks before examination. She then noted a peculiar "glare" when light would strike her eyes, with a slight dull pain behind the right eye. Shortly afterwards she noticed diplopia. The mother of the patient is a diabetic.

Examination revealed a paresis of the superior rectus of the right eye; all other findings were normal. Vision was normal with correction.

The urine was normal; blood sugar was 146. Sugar tolerance test showed a typical "diabetic curve" of the mild diabetes type.

The patient was put on a reducing diet in view of her obesity, was given vitamin B-complex and vitamin B-12 orally.

The double vision cleared up very promptly; in fact, it had started to improve before the vitamin therapy was started.

CASE FOUR

Home controlled diabetic showing rapid improvement with better regulated hospital regime.

This 62 year old obese hypertensive (170/100) female with diabetes of nine years' duration, complained of sudden diplopia two weeks before hospitalization while under a local physcian's care. Although under fair diabetic control at home, she showed palsy of the right abducens nerve, unequal upper extremity reflexes, absent knee and ankle jerks, reduced vibration sense in all extremities, absent below the ankle. She gave a past history of pain in the soles of her feet for several months. This was treated by a physician as arteriosclerosis obliterans. In the hospital she developed severe depressive symptoms with headache, nausea and vomiting. After a stormy course, she gradually improved and within a few weeks the diplopia disappeared, her stomach was free of symptoms, and the feet were comfortable.

Comment on Cases 3 and 4. We have mentioned the work of Weinstein and Dolger[10] on extra-ocular muscle palsies in diabetes mellitus. They conclude that findings like those described in our cases are best explained on the basis of small hemorrhages in individual nuclei of the third and sixth nerves. This does not seem a likely explanation in case 3 because the patient is only 37 years old and (except for the very mild diabetes) is in perfect health. In both cases, as so often happens, the palsy cleared up completely within a few weeks. This would have been very unlikely, had it been caused by a hemorrhage into the corresponding nucleus. We believe, rather, that there was a "neuritic" involvement of varying numbers of fibers in each case; selectively the fibers for the superior rectus within the oculomotor nerve in case 3. Isolated fiber involvement has been accepted for traumatic palsies of parts of the oculomotor innervation in cases of fracture at the base of the skull.

CASE FIVE

Progressive, irreversible neuropathy in a poorly controlled, undernourished, luetic diabetic.

This 56 year old housewife, was discovered to have diabetes and congenital syphilis sixteen years ago, the blood Wassermann showing reversal after two years of intensive systematic antiluetic therapy. Control of this patient's diabetes was unsatisfactory during a major portion of the 16 years; on repeated hospitalizations attempts were made to control her diabetes with diet and insulin. She cooperated poorly; often would not eat properly; would go without adequate food. During long stretches, insulin was either refused by the patient or was not feasible because of repeated insulin reactions brought about by inadequate or irregular food intake. A few years after the diabetes was first found, ophthalmoscopy revealed the typical picture of diabetic retinopathy. Six months ago, with the diabetes evidently out of control for some time, she began to show progressive general muscular weakness, marked weakness of the legs and ataxia.

On examination she showed the old diabetic retinitis with signs of peripheral neuropathy, namely the marked weakness mentioned above, absence of the tendon reflexes of the legs, reflexes in upper extremities sluggish or missing, and diminished or absent vibratory sensation in the legs.

While the blood and spinal fluid Wassermann were again negative, there was, this time, an increase in the spinal fluid globulin. Spinal fluid protein was elevated to 89; the cell count showed two red cells and no white cells.

In spite of diabetic management, her condition has become progressively more severe. On her last admission three months ago, she was extremely weak and could not even stand without assistance. The weight loss that had been marked in the last ten years recently became critical. The picture, in addition to the peripheral neuropathy, was that of an arteriosclerotic dementia. The patient was placed in a "home for incurables" but soon had to be transferred to a state psychiatric hospital.

Comment: An interesting feature is the increased spinal fluid protein in this very chronic and purely "degenerative" type of diabetic neuropathy. Epstein[9] found among 25 patients who belonged to the arteriosclerotic group of "diabetic neuritis", elevated spinal fluid protein in 10. He recognizes, however, that the highest values were obtained in cases without arteriosclerosis. It is doubtful whether the "burnt-out" syphilis contributed to the high spinal fluid protein since previous spinal fluids had been normal; and the colloidal gold reaction was a "straight" line.

CASE SIX

Diabetic pseudotabes with agitated depression. Neurologic symptoms improving when psychosis goes into remission; recurring on relapse.

This 64 year old housewife with diabetes of several years' standing, give a history of progressive ataxia for the past few years. Examination revealed generalized arteriosclerosis with the retinal vessels showing irregularity, silver streaking, nicking of the veins and several hemorrhages but no exudate. In the upper extremities reflexes were sluggish; there was reduced vibration sense and marked overshooting on point-to-point tests. In the lower extremities she had absent reflexes, marked ataxia and swaying, absent vibration sense, reduced pain and temperature sensibility below the knees.

This patient suffered from marked depression with agitation, crying, ideas of hopelessness and death, and moderate memory defect for the immediate past. These spells of depression were recurrent in the past five years, generally cleared with a few electro-convulsive treatments with marked improvement of the ataxia and muscle weakness, each time.

CASE SEVEN

Differential diagnosis from pernicious anemia.

This 62 year old female with fifteen years of diabetes suffered from several periods of vomiting and acetonuria necessitating hospitalization. She said that she was not "sure" of herself in walking.

This symptom has been intermittently present for one year, with numbness of the lower extremities to the thighs for several months although "dead toes" had been present for two years. She also noted some paresthesias in her fingers. All symptoms had progressed rapidly two weeks before examination following a fall down the cellar stairs.

Neurologic examination revealed complete inability to stand up without support, overactive reflexes in the upper extremities, absent abdominal reflexes, left knee jerk more active than right, absent ankle jerks, and a positive left Babinski. Pin prick sensation was reduced to the level of the knees, tuning fork sensation to the level of the ribs, and vibration sense was reduced in the finger tips. The pyramidal tract signs, absence of appreciable pain, marked posterior column signs suggested combined system disease. This tentative diagnosis was supported by achlorhydria and a red blood count of 3.2 million, a 75 per cent hemoglobin with moderate irregularity in the size and shape of the red blood cells. Improvement with reticulogen, fortified, 1 cubic centimeter daily, occurred quickly.

CASE EIGHT

Tumor of cauda erroneously diagnosed as diabetic neuropathy.

This 49 year old housewife was referred for consultation 2½ years ago because of very distressing paresthesias in the rectum "like a bunch of bees and ants" of about 1½ years' duration. She has been a diabetic since the age of 40, used insulin in addition to her diet. She had been proctoscoped twice with normal findings. Though there were no other signs suggestive of diabetic neuropathy (no sensory changes in the legs including the saddle area; tendon reflexes present, eye grounds normal), a tentative diagnosis of visceral diabetic neuropathy (of the rectum) was made and the addition of B-1 and B-complex therapy to the present management of the diabetes was recommended.

The patient drifted away after one office visit. Subsequently it was learned that her distress in the rectum had become gradually worse and she was admitted to the hospital one year ago (almost 1½ years after we had seen her and almost 3 years after her symptoms had begun). An important finding at that time was the absence of the Achilles reflexes (present 1½ years before, at the time of our examination). A myelogram definitely suggested a mass in the cauda equina region. Operation revealed an extra-dural tumor. This was completely removed. The pathologic diagnosis was lipoma. She died 13 days after the operation from an acute pulmonary embolism, although she had been recovering uneventfully from the operation and was ready to go home when the embolism occurred.

Comment: Spinal puncture and myelography of the cauda equina region should have been done when the patient was first seen. Unfortunately, we were too engrossed by recent literature about visceral diabetic neuropathy and, the patient was seen only once and never returned for review and reevaluation of the first diagnostic impression.

Footnotes and citations appear in the authors' reprints

434 Park Avenue

CORTISONE IN TRICHINOSIS

Trichinosis is one of the few parasitic infections which is not uncommon in temperate zones. Although it is frequently a mild and self-limited disease, in severe cases the mortality may be as high as 62 per cent, and the symptoms can be very troublesome. It is characterized in its early stages by general malaise, weakness, profuse diapedesis, abdominal pain with cramps and diarrhea, as well as periorbital edema, conjunctivitis and photophobia. Eosinophilia usually accompanies this stage, which is believed to be an allergic reaction to the offending organism. The familiar muscular aches and cramps are due to the encystment of the trichinella in the muscles, with resulting foreign body reaction. Previously treatment of trichinosis has not been satisfactory. Because of the known action of ACTH and cortisone in the alleviation of allergic states, the latter drug was used in the treatment of a case of trichinosis, with excellent results.* After a four day control period, therapy with cortisone was started in a 42 year old patient in whom the diagnosis was established by muscle biopsy. During treatment the patient's fever disappeared, his symptoms abated, and the eosinophile count dropped to normal. Following a second course of therapy he remained symptom-free for one month, although the eosinophilia returned. The author suggests that this form of treatment be explored in other cases of trichinosis.

*Rosen, E.: Cortisone Treatment of Trichinosis. American Journal of the Medical Sciences, 223:16 (January 1952).

THE OFFICE MANAGEMENT OF LOW BACK PAIN *

INCLUDING THE CARE OF THE INDUSTRIAL BACK

Henry H. Kessler, M.D., Newark, N. J.

Before the advent of science, the explanation of all human behavior was based on irrational ideas. The lack of an organized body of knowledge forced the inhabitants of primitive society to explain all of the material forces about them by means of superstition, animism, anthromorphism and demonology. Things which could not be explained were thought to be the work of evil spirits and forces. History is replete with examples of how the devil was exorcised by fire, sword and prayer. Despite centuries of enlightenment, we still tend to regard the unknown and the unexplained as being in league with the devil, sin and evil spirits.

The whole concept of *low back pain* fell heir to the same primitive and irrational consideration, At one time low back pain was called *hexenshuss,* or witches' blow, as a tribute to the old animistic explanation of its etiology. Still later, the term *lumbago* came into use, to be followed by the more recent *sacro-iliac sprain,* and now the condition is known as *low back pain.*

Today, we still exorcise low back pain with fire and sword in the form of surgery, and with prayer in the form of physical therapy. There is an obvious need for reason in our thinking, to lay the ghosts of an irrational era in the history of medicine.

In a thirty-year practice of medicine, one sees the rise and fall of many sacred cows. The whole spectrum of attitudes, from pure dogmatism to bitter skepticism, helps to mold our practice and our ideas. Nowhere has this been more true than in low back pain. Influenced by our teachers and modified by our own experience, we soon develop a pattern of ideas which has definite significance to us in diagnosis and treatment.

The first step in a rational approach is to know what we are talking about. While it may be convenient to lump spinal cord tumor, Struempell-Marie arthritis, herniated disk and multiple myeloma together it is obvious that such an attitude can only invoke irrational treatment with a tragic or even fatal outcome. Without a satisfactory diagnosis, using all of the tools at our command, one cannot carry out any sensible plan of treatment for low back pain. How often have we been humbled to find the terrible psychoneurotic turned out to have a malignant metastasis of the spine, or that the congenital anomaly of the spine which was fused turned out to be a Struempell-Marie arthritis?

Until the appearance of the revolutionary Mixter and Barr concept of affections of an interverterbral disk as a cause of low back pain, we were content to circumscribe our diagnoses into mechanical and nonmechanical factors. Of the nonmechanical factors, rheumatoid arthritis in its special form of Struempell-Marie arthritis took an important position. As for the mechanical factors, osteo-arthritis, weak feet, and poor posture commanded our attention.

In the pre-disk days, sciatic pain was not considered a purely orthopedic problem. However, its associate, a sacro-iliac sprain, which occurred sometimes independent of sciatica, loomed large as an orthopedic problem.

Diagnosis, therefore, was performed by intuitive correlation, that is to say, a quick consolidation of experience in which we thought instinctively of these factors. Although rare disease, bone tumor, osteomyelitis and affections of other organs did not play an important part in our conscious diagnosis, they hovered somewhere in the background ready to be identified when a frank clue or revealing symptom made the diagnosis obvious.

After the acceptance of the concept of the herniated disk, these earlier factors began to recede. More and more, each patient with low back pain who entered the office was first con-

* Read before the Section on Orthopedic Surgery at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1952.

sidered to be a case of derangement of the disk. All of the other diagnoses assumed a secondary place, to be thought of only when x-ray, clear-cut history or physical findings made the conclusion unmistakable.

While this paper is concerned with the conservative *treatment* of low back pain, it must be concerned with conservative *diagnosis* as well. I have been influenced in this attitude by experience with the rehabilitation of severely disabled persons. It is impossible to estimate the rehabilitation potential of a paraplegic, an amputee, a hemiplegic, a multiple sclerotic, an old fracture deformity or a severe poliomyelitis by a single examination. Only after close observation over a satisfactory period of time can such an evaluation be made. In poliomyelitis, for example, repeated muscle tests help determine the status of the lesion. In paraplegia, the conservative score of activities of daily living and progress in ambulation provide an estimate of the patient's condition and possibilities. In a bilateral arm amputee, the development of manual skills for working and living are as much diagnostic tools as the stethoscope, x-ray or blood test. It is necessary, therefore, in establishing the diagnosis to use not only the usual tools of diagnosis, but *time* as well.

When our diagnostic measures have been completed, we find one group of conditions that, for want of a better term, might be called *mechanical* lesions producing low back pain. Even here, while we presume that the etiologic factor is some deviation of known body mechanics, result of skeletal defect, muscle strain, disease or injury, the exact cause itself is still frequently obscure. The symptoms of low back pain (with or without sciatica), may be exactly the same in variation of mechanical derangements, including anatomic variations in the lumbosacral skeletal complex, in the physiologic changes taking place in the intervertebral disk, and, in reflex phenomena of adjacent or even remote pathological lesions. It is not necessary to have a herniated disk to produce the same syndrome. Hirsch, has repeatedly demonstrated his ability to produce this entire train of symptoms by transdural puncture of the intervertebral disk.

TREATMENT

The aim of all treatment is to relieve pain, to restore function, and to restore working capacity. Treatment of the low back case falls into two categories: treatment of the deranged disk, and treatment of all the non-disk cases. Since we are concerned with conservative and office management of low back pain, I am grouping together and thinking in terms of three entities: (1) mechanical derangements involving the disk, such as minor subluxations of articular facets, postural defects, ligamentous strains, muscular strains; (2) degeneration of the disk; and (3) prolapse of the disk.

John Hunter, a long time ago, directed our attention to "the natural disposition to restoration" as a fundamental feature of the wisdom of the body. In other words, *rest is still one of the cardinal methods of treatment,* and one of the safety factors in the human economy. Rest can be achieved through recumbency, with or without traction, or with support in the form of soft or rigid braces. Rest in the form of bedrest or splinting by braces is still a satisfactory method, but one which is constantly overlooked because of the pressure of business and personal problems on the patient. Rest can also be achieved through more intensive immobilization by means of a plaster jacket.

Years ago I used this form of treatment to a larger extent than I do today. It is now unfashionable to ask a businessman or worker, caught up as he is in an eddy of social and economic forces, to devote an adequate period of time to allow his temporary injury or derangement to heal by natural means. Immobilization by plaster jacket remains a satisfactory treatment.

Manipulation is a field of treatment which has been largely overlooked by orthopedic surgeons, one in which the chiropractor and the osteopath, particularly the latter, have almost taken over. There is still room for manipulative surgery in many of the acute conditions of low back pain. The maneuvers are not difficult to learn and at least 25 per cent of the cases of low back pain that have come to my attention have been helped by manipulative treatment.

Some years ago Captain Kreusz of the United States Navy gave a dramatic demon-

stration of quick relief in cases of acute low back pain with sciatica by injections of Novocain† into the piriformis muscles. These patients hobbled with considerable difficulty to the platform, some with crutches and canes; all of them walked from the platform with little or no limp and little or no disability. For a time, piriformis injections became a fashionable method of treatment. While it is still valuable, it cannot solve the problem of the primary cause. It merely provides relief from secondary muscle spasm.

The management of the degenerated disk has also seen a wide range of attitudes and treatment, from pure conservatism to radical surgical treatment. In the management of the disk case, or, for that matter, any case of low back pain, one is influenced to a large extent by one's own background and studies.

Two influences have been among those which shaped my own thinking about low back pain. One was an interest in special studies in physical anthropology to which I was fortunate to be exposed twenty years ago. I learned of the tremendous anatomic variations in all parts of the skeleton and especially in the spine. I learned about the constant number of cervical vertebrae, the rather constant number of dorsal vertebrae, and the greater degree of variation in the lumbar spine. I also learned that the lumbosacral complex of the vertebral column was the most recent in the evolution of the spinal column, and that anatomic variation is so great in this area that it is impossible to specify a "normal" or standard anatomic complex. This has helped me to avoid attaching undue importance to the usual clinical interpretation of malfunction associated with anatomic variations, including spondylolisthesis, lumbosacral fusions and so on.

At the 1947 congress of German Orthopedic Surgeons, in Heidelberg, a German physician who had been a prisoner of war in Texas gave a superb exposition of the American point of view. He had been exposed to the American concept of the intervertebral disk as a cause of low back pain and he had seen American methods and technics to relieve this condition. He described the many surgical procedures that were being carried on in the United States. When he completed his talk, his German colleagues gave one large gasp. They had never treated low back pain with sciatica (which they called ischias) by any but conservative means: hot air, baths, physical therapy and electricity. It was a great surprise for them to learn that surgery was even being considered as a means of treating low back pain.

Thus one sees two ideas, conservatism and radical (or surgical) treatment. Certainly, neither is absolutely right for all cases. Certainly, in a large proportion of cases, low back pain with sciatica should receive a reasonable program of conservative treatment. This would include bedrest, traction, immobilization in a plaster jacket, appropriate braces and systemic exercises. The threshold of pain varies so greatly in different individuals that it is sometimes difficult to determine the period of acute disability. Once that is done, a more direct attack on the pain can be undertaken.

INDUSTRIAL BACK PAIN

To all of the complexities associated with the problem of low back pain, one may add another, the emotional factor. In the industrial back cases, the normal doctor-patient relationship is saddled with a multiplicity of new elements: the state, the employer, the legal profession, insurance companies, rating boards, workmen's compensation bureaus, social workers, personnel offices, and so on *ad infinitum*. The permutations and combinations of these interested groups revolve about a basic issue of hope of financial gain. The personality of the injured worker and the whole course of his disability is so affected by these factors that it would be a mistake to overlook or underestimate them. A chance statement by a physician which magnifies the disability in the patient's eyes, the deliberate machinations of the "ambulance chaser", the efforts of the union representative to get a "square deal" for his client and the activities of the insurance adjuster can transform a simple case of injury into a cause requiring months of litigation. There is a persistence of incapacity beyond all normal expectations. Furthermore, the referee

† Novocain is the trade-name given by Winthrop-Stearns, Inc., to their brand of Procaine hydrochloride.

or industrial commissioner soon lends his efforts to perpetuate a system of jurisprudence that was never meant to be. Talmudic scholars, medieval philosophers and the dialecticians of ancient Greece carried on no such abstruse discussions as take place in compensation hearings. The relationships between injury and disease and the fine mathematical evaluations of disabilities have little relevancy to everyday working conditions. Nevertheless this is the material with which compensation hearings deal. The hearing room is more like a sports arena than a sober forum.

In a climate of this sort, there are obvious difficulties in making an adequate diagnosis, in providing satisfactory treatment and restoring the individual to his normal working capacity. Nevertheless, one can still establish an adequate diagnosis. One can still employ conservative methods of treatment; in fact, because of the emotional factors in the industrial case, there must be a prolonged test of conservative methods before any surgical measures are contemplated. *Indications for surgery must be so unmistakable as to leave no room for doubt.* The results of surgery in industrial low back cases have been notably poor. Surgery does not solve all of the problems even in the nonindustrial case. The removal of a prolapsed disk does no more than relieve pressure on the nerve root; the pathologic changes in the disk remain uninfluenced. The degeneration proceeds, and as a consequence, postoperative low back pain continues. Nor is spine fusion a complete answer since even in so-called fused spines a certain amount of motion still continues. This provides enough play in the intervertebral foramina to produce stretching or even compression in the emerging nerve roots.

Two textile companies in Vermont had a unique experience with injured backs some years ago. They each employed about the same number of men from the same homogeneous population, and carried out the same industrial activities. Both plants had part-time industrial physicians. In the first plant, loss of time for back injuries and cases of compensation for back injuries were twenty-five times that of the second plant. This seems odd. The lesions were the same, the working conditions were the same, and the type of employee was the same. What was the explanation? In the plant with minimal loss of time and minimal compensation loss, it was the habit of the industrial physician to minimize the emotional effects of the injury to the patient. The patient would report to the doctor with pain in the back. The doctor would strap his back and send him to work immediately. No time was lost, the symptoms gradually subsided, and there was little or no compensation loss. Occasionally, with the cooperation of the foreman, a slight change was made in the patient's job, but the principle of returning the man to work was a definite policy. In the other plant the patient was sent home or, often, to a hospital, given prolonged bedrest followed by bracing and/or physical therapy and soon magnified in his own mind the character and extent of the disability. One can now understand the difference in the effects of industrially injured backs in the two plants.

SUMMARY

Low back pain presents many problems. As to etiology and methods of treatment and management, certain fundamental principles should be respected: namely, that assuming all nonmechanical factors have been eliminated, the condition can be treated on a mechanical basis. Rest, support, time and a healthy physician-patient relationship are still satisfactory methods of treatment.

53 Lincoln Park

CIVIL DEFENSE PAMPHLET AVAILABLE

A brochure on the medical aspects of civil defense has been prepared by the American Medical Association and is now available from the A.M.A. Headquarters in Chicago at 25 cents a copy. This 130-page booklet covers all facets of the medical features of civil defense.

HEREDITARY HEMORRHAGIC TELANGIECTASIA*

(AN UNUSUAL CASE HISTORY)

Albert Abraham, M.D., Morristown, N. J., and
Gabriel Yelin, M.D., Newark, N. J.

Hereditary hemorrhagic telangiectasia is a well known clinical syndrome, described by many, including Osler, whose name it sometimes bears. This syndrome which is sometimes said to be the result of a capillary defect may be of two types: one with prolonged capillary bleeding time, the other with increased capillary fragility. The usual diagnostic criteria are:

1. A family history of bleeding
2. An individual with persistent bleeding
3. Diffuse mucocutaneous telangiectasia, which because of diffuse vascularity may involve any organ.

The most commonly described lesions are those of the nasopharynx, skin, lungs and gastro-intestinal tract. The following case history is presented because of the various unusual aspects.

A 72 year old white male was admitted to the hospital on October 27, 1947. He was referred because of sudden onset of weakness, pallor, and shortness of breath. He had been subject to frequent nosebleeds. No history of familial disease was elicited. On the evening of admission he suddenly became very short of breath and "white as a ghost". Six weeks prior to admission his shoes seemed to be tight because of ankle swelling and he had become short of breath even at rest. Several days before admission he became weak and experienced a "clamping" type of pain in his upper abdomen and chest which radiated down the inside of his left arm. This was an isolated episode.

On admission, he appeared acutely and critically ill, in marked respiratory embarrassment and with skin extremely pale. Mucous membranes were practically devoid of color. Other significant findings were: pulse rate, 120; respiration rate, 50; blood pressure, 120/60. Numerous, coarse, moist rales were audible throughout the lungs. Heart size, rhythm and sounds were normal. There was no murmur or thrill. The liver was enlarged three

*From the Veterans Administration Hospital, Lyons, New Jersey.



Figure 1.

fingers' breadths below the right costal margin. There was no pretibial edema.

Laboratory studies on admission were as follows: erythrocytes 1,700,000; hemoglobin 2.9 Grams; leucocytes 12,000; chest x-ray examination revealed mottled infiltrations at both basis, cardiac enlargement, and calcific plaques in the aorta.

Admission diagnoses were: (1) a. arteriosclerotic heart disease; b. coronary sclerosis, acute myocardial infarction; c. decompensated, normal sinus rhythm; d. class IV; (2) severe anemia, type and cause undetermined.

Course in hospital: The patient was immediately given transfusions of blood and plasma, infusions of glucose in distilled water, and a meralluride diuretic. Later he received digitoxin and symptomatic therapy as indicated. In a short while the patient began to improve. In a few days he became free of cardiac failure. The serial electrocardiograms revealed the gradual development and resolution of an atypical Q1—T1 pattern. In four weeks he was completely free of symptoms and signs of cardiovascular disease. Intensive laboratory, x-ray and esophagoscopic study did not reveal the cause of the severe anemia noted at the time of admission. The patient persistently had a microcytic hypo-

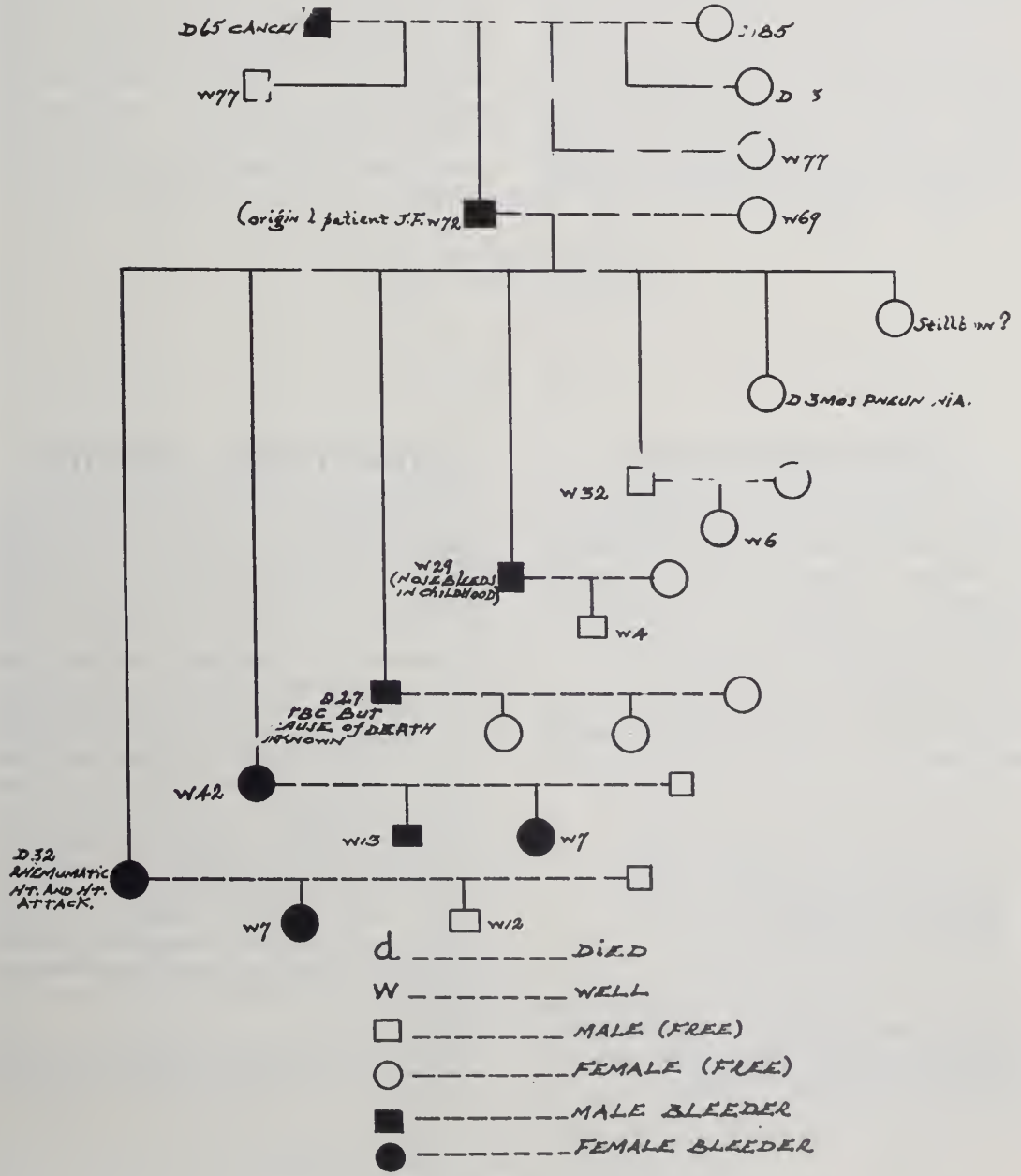


Figure 2.

chromic anemia. At this time it was noted that he had frequent and persistent nosebleeds, and also that he had diffuse telangiectasia of the skin and nasopharyngeal mucous membranes. He had suffered these nosebleeds as long as he could remember. It was then evidenced that the anemia was secondary to the frequent nosebleeds, resulting from telangiectasia.

At this point the patient was again questioned with reference to the family history. This revealed a definite familial history of abnormal nosebleeds. Seven of the patient's fifteen descendants were known to suffer from this condition. One daughter, described as "a bleeder", died at the age of 27 of a "heart attack", type unspecified. Although she was previously known to have had rheumatic heart disease, she may also have had an anemic infarction. One son died at the age of 29 while hospitalized for pulmonary tuberculosis. The records are not available but it was stated that the cause of death was *not* tuberculosis. No one had ever noted as a family characteristic the skin lesions of telangiectasia. The genealogic chart indicates the interesting inheritance pattern in this family. The bleeding tendency does not appear to be sex-linked. The patient continued to have nosebleeds during the remainder of his hospitalization. He also developed pulmonary symptoms and died on January 21, 1951. Postmortem examination revealed a bronchogenic carcinoma. Detailed examination of the heart showed a moderate amount of coronary atherosclerosis but no coronary occlusion and no residual evidence of myocardial infarction.

SUMMARY

We have presented an usual instance of hereditary hemorrhagic telangiectasia complicated by acute myocardial infarction. The patient had nosebleeds for most of his life and accepted them as an ordinary occurrence. Eventually, however, he became so anemic that he required hospital admission. This man suffered a myocardial infarction on the basis of anemia with resultant anoxemia rather than on the basis of coronary occlusion.

139 South Street, Morristown
202 Clinton Avenue, Newark

UNITED DEFENSE FUND

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American Relief for Korea
American Social Hygiene Association
United Seamen's Service
National Recreation Association

These services are needed so long as American young men and women are in the nation's armed forces and so long as civilian lives are complicated by defense production.

CONTACT LENSES AND OXYGEN

Ophthalmologists and users of contact lenses will be interested to learn that normal corneal function depends on access to atmospheric oxygen. In experiments done at Columbia University* it was found that haziness and halo formation in the visual fields resulted when contact lens were used by trained subjects wearing diving goggles in which nitrogen was introduced. On the other hand, these visual disturbances did not occur when moist air or air-carbon dioxide mixtures were used to fill the goggles. Introducing oxygen into contact lenses through stoppered openings enabled these subjects to wear them for seven hours without halo formation, in contrast to four hours without added oxygen.

As a result of these studies the authors suggest adding bubbles of oxygen to contact lens fluid, so that users may wear them for longer periods without halo formation or haziness.

* Smelser, G. K., and Oznics, V.: Importance of Atmospheric Oxygen for Maintenance of the Optical Properties of the Human Cornea. Science 115:140, February 8, 1952.

SLUM TUBERCULOSIS

Irving Willner, M.D., Newark, N. J.

Slums are the festering sores of a city. They create a major health hazard. Here are areas with dilapidated dwellings often having no decent methods of sanitation. They have existed in every large city for generations.

The exodus from small towns to larger cities (because of higher wages) usually leads to an acute shortage of urban living quarters. Soon the only accommodations available are in these deplorable sections. Slums attract the poor and the ignorant to areas where there is total disregard of decent and hygienic living. Economic necessity compels many individuals to sediment into these areas. One of the large industrial centers with a great demand for skilled and unskilled labor is Newark, New Jersey. Better incomes have lured many families from the south and from rural areas. This rapid influx found the city unprepared to provide adequate housing. As a result many families settled in decrepit dwellings unfit for human habitation. During World War II, no new housing was built. More and more buildings needed repairs. There was a labor shortage and material was hard to get. As a result, many of these areas deteriorated into filthy slums. These homes have faulty plumbing, often with no water supply; no baths, and inadequate toilet facilities. Overcrowding soon saturated these sections. Often three or more families occupy a flat intended for one. Even attics and cellars are "homes". Many residential structures have deteriorated to such an extent that they are no longer fit for use. Owners have allowed these dwellings and tenements to deteriorate because income would barely pay taxes with nothing left for repairs. These dwellings constitute a slum and form an incubation culture medium for the development and spread of tuberculosis. The slum area now involves about one-twelfth of the city covering 1200 acres.

Poverty, with its resultant poor food, poor housing, over-crowding, personal anxiety, deficient sanitation and inadequate medical care diminishes resistance to infection. *There is a definite and positive relation between concentration in slum areas and death rate from tuberculosis.* Congested and squalid homes are a disgrace and a menace. From the nearby neglected home, tuberculosis can spread to other sections in spite of better living conditions in those areas. Close contact facilitates transfer of infection from one person to another. Tuberculosis flourishes in slums.

A thorough survey of 2010 dwellings in a single ward[1] in Newark revealed deplorable housing, congestion, sub-standard sanitation and close association with active cases of tuberculosis. *Careful inspection revealed only 7 per cent in good condition.* Most of the structures are more than a generation old, and no new buildings have been erected for years. Fifty-four per cent needed major repairs, 80 per cent were infested with rats, mice and vermin and 94 per cent showed sanitary violations. Houses unfit for human habitation numbered 15 per cent. These figures portray hygienic conditions in a slum area. This problem exists in all large industrial cities.

A campaign was recently initiated to clean out a slum area centering at Nassau Street and Nassau Place in Newark.[2] This section, colloquially called "Tobacco Road", consisted of sixteen dwellings. All houses were unfit for human habitation and had been condemned by inspectors of the Sanitary Division. The roofs were in need of repair, walls and ceilings were broken and there was no water supply for kitchen or toilet. Some flats had no toilets at all. Windows were absent and there was total disrepair. There were 43 tenants. Among this small group, investigation revealed nine known cases of active tuberculosis under supervision of the Department of Health. Further study revealed that two individuals, previously residing here, had died of tuberculosis in 1948. Legal action was instituted listing specific unhealthful conditions. Notices were also served on the tenants to vacate. These

1. The Third Ward.
2. In the First Ward.

buildings were condemned in court proceedings as unfit for habitation and ordered demolished.

The low standard of living and associated factors of congestion, over-crowding and malnutrition form the basis for development and spread of infectious diseases. If an active case of tuberculosis is unknown and untreated, contamination of contacts is rapid. Tuberculosis is not congenital. Contact with persons having positive sputa spreads the disease. One Newark ward,[1] which is very densely populated has a concentration of some of the oldest and poorest dwellings. This ward has a population of 26,000. In 1950, the actual number of tuberculosis cases was 89 and deaths numbered 33. Morbidity rate per 100,000 was 342. The tuberculosis mortality rate per 100,000 was 127. There are now 134 families being supervised. This ward[1] has 90 active cases of tuberculosis, most of them now in the sanatoria or City Hospital. There are 503 apparently arrested cases being checked frequently by x-rays, clinical examinations and sputum analyses. In this area, two housing developments have existed for about ten years, the Prudential and the Felix Fuld Housing Projects. In the first, 720 families reside, and in the latter 300. These developments together occupy about 5 per cent of the ward's area. All known active cases in the new housing projects are now in sanatoria.

	Active Cases	Apparently Arrested	Population
Prudential	8	42	1,500
Felix Fuld	3	15	3,600
Total Ward	89	503	26,000

Improved housing and better sanitation shows a much lower morbidity than in the rest of the same ward.

The unknown case forms the greatest hazard and only when located and treated, can it be kept under control. As long as conditions exist where the germ spreads and propagates, tuberculosis will continue. In spite of all case finding methods, a large number of active tuberculous individuals are never located. They are not recognized or diagnosed until just before or after death and have never been under control. Over many years they wander about infecting and spreading the disease without the knowledge of any one. Records of the Newark Health Department show that within the past five years the following proportions of individuals with tuberculosis were not discovered until after their death:

1946	65	25%
1947	40	16%
1948	48	21%
1949	49	23%
1950	76	37%

Almost all of these have resided in the slum areas. Imagine how many individuals could have developed the disease by contact with them during their infectious state! They wander among the public, in buses, crowded stores, theatres, et cetera, spreading their infection.

Slums must be abolished. There must also be a general improvement in housing conditions and in the sanitary and hygienic measures that will follow this procedure. In Newark the condition has become so serious that large areas will have to be repaired or entirely demolished. An advisory Board appointed in 1947 to study housing conditions concluded that "of the estimated 118,550 dwellings now existing in Newark, 38,423 or 32 per cent either needed major repairs or lacked private baths, private toilets or private water supply." This committee found that 2200 new units are now needed and 22,000 dwellings that are not completely dilapidated would have to be rehabilitated. Buildings unfit for use should be closed or removed. All dwellings to be repaired must comply with accepted standards of health. Destruction of the slum sections will lead to a drop in both morbidity and mortality of tuberculosis. *If the Tenement House Laws now existing are rigidly enforced there will be a greater drop in the tuberculosis rate than can be produced by educational methods.*

In spite of the difficulties encountered by slum conditions, the city has a death rate for 1951 which is the lowest in its history. This death rate for 1950 had fallen to 47.2 and declined in 1951, through vigorous effects to 38.1. These figures demonstrate that by intensive effort with modern modes of tuberculosis control and in spite of major obstacles

there still can be a reduction in tuberculosis death rates. Hopefully slum clearance will come, and the full impact of the control measures will then show far greater progress toward ultimate eradication.

The primary aim of this paper is to acquaint the medical profession of existing conditions which breed tuberculosis in slums of a large industrial city. Congested and unsanitary sections and rooming houses frequented by floaters, alcoholics and derelicts are a blot on a progressive municipality. Too much stress has been placed on the contagious aspect of tuberculosis and too little on the predisposing causes. When communities are properly constructed and standards of health improved, they will reflect a drop in infectious diseases. A drive to improve slum conditions has been going on for years, but the solution lies not in improvement, but in eradication. Much has been done in housing, but as far as tuberculosis is concerned, only the surface has been scratched.

94 William Street

THE "LINCOLN SYSTEM" OF TREATMENT

From time to time, the Society has received inquiries about the "Lincoln System" — a method of treating degenerative and infectious diseases by having the patient inhale bacteriophage. The following extract, from the March 27 (1952) *New England Journal of Medicine* summarizes the situation to date:

On July 19, 1948, a paper purporting to present a new and important method of treatment of certain infectious diseases was submitted by Dr. Lincoln for publication in the *Journal*. It was given unusually careful consideration because of Dr. Lincoln's insistence on its importance, but it was rejected on August 26 as unsuitable for publication. This, however, did not end the matter; in consideration of Dr. Lincoln's importunacy the merits of the paper were once more reviewed by the board of editors before it was again returned to him in September. During the course of the discussions legal action was threatened by Dr. Lincoln if his method, for which he had applied for patents was appropriated by any member of the board.

This final rejection was followed by the receipt of letters from various of Dr. Lincoln's patients, virtually accusing the *Journal* and the Massachusetts Medical Society of willfully and selfishly depriving the public of the benefits of a great medical discovery. Since these protests were made in the interests of a Fellow of the Massachusetts Medical Society, Dr. Lincoln was asked to meet with certain officers of the Society to discuss his therapeutic methods and present their claims to distinction, if any. The meeting took place in July 1949, at which time an offer was made to him of a scientific survey of his form of treatment by an impartial board, which he should help to select. He was asked to submit names of persons to serve on such a committee, but he failed to do so.

Largely because of the interest of Senator Charles W. Tobey and his son, a former patient of Dr. Lincoln, publicity increased until the affair became a *cause célèbre*. A Lincoln Foundation Trust was established on May 18, 1950. On June 6, 1951, because of charges that were brought against him, the Committee on Ethics and Discipline of the Massachusetts Medical Society asked Dr. Lincoln to appear before it and explain his obviously unusual system of practice, in which all diseases were treated indiscriminately by the inhalation of one or more solutions of bacteriophage. As a result of this interview the president of the Society appointed a special committee to study the "Lincoln Therapies". A diversified committee was necessary because Dr. Lincoln's claims of successful treatment now concerned not only the known infectious diseases but cancer, multiple sclerosis and, indeed, practically all the ills to which human flesh is heir.

The details of the committee's seven-month investigation have been reported in full and need not be related here; much revealing evidence was obtained, despite the fact that the committee's efforts at securing information concerning the nature of the bacteriophages that comprise the active principles of the treatment, and a complete laboratory study of both their safety and their activity, never met with that degree of cooperation that might have been expected of a Fellow of the Society.

Meanwhile, Senator Tobey had put the *Congressional Record* to a novel use—as a means of publicizing both Dr. Lincoln's work and his relations with his Society; several inaccuracies seem to have been preserved for posterity therein. So far as is known, this is the first time that the *Congressional Record* has been employed for the promotion of a proprietary medicine.

The final report of the committee contained evidence of inadequate or totally neglected examination of patients, uncertainty of diagnosis, lack of adequate records and ineffectiveness of the treatment, in addition to its being dependent on a secret remedy. Charges were subsequently brought before the Society's Committee on Ethics and Discipline, Dr. Lincoln was found guilty as charged, and his resignation from the Society was requested.

STATE ACTIVITIES

TRUSTEES' MEETINGS

APRIL 27, 1952

A special meeting of the Board of Trustees was held on Sunday, April 27, 1952, at the Executive Offices, Trenton. The following is a summary of the principal actions taken by the Board at this meeting:

After protracted consideration and discussion of a complaint made by Medical-Surgical Plan regarding the adoption and distribution of a resolution by the Mercer County Medical Society with reference to the suggestion of Medical-Surgical Plan that part of surgical payments be made to eligible physicians assisting in the care of the patient, a motion was unanimously adopted requesting the membership of the Mercer County Medical Society to withdraw its resolution and to circulate notice of its withdrawal among the same persons who received the original resolution.

The Trustees considered resolutions from the Camden County Medical Society dealing with (a) fee schedule; (b) removal of income limitation; (c) payments to eligible physicians in surgical cases; (d) identifying the income bracket of Medical-Surgical Plan subscribers; and (e) the re-examination of the problem of participation of The Medical Society of New Jersey in Medical-Surgical Plan of New Jersey. The Board then unanimously adopted a motion assuring the Camden County Medical Society that their resolutions would be properly and fully studied in an attempt to arrive at satisfactory dispositions thereof.

Approval was given to a report of the steps taken by the special committee for the accomplishment of a Governor's veto of S-139, the Chiropractic Bill. The report was submitted by Dr. Sigurd W. Johnsen, chairman of that committee.

In response to the request of Dr. Johnsen for advice regarding future actions of the committee, the Board adopted a motion directing that the special committee strive to ascertain the attitude of the Governor toward the bill and press for the veto of the bill. In the event that the veto is not forthcoming, the committee is empowered to offer the cooperation of the Medical Society in preparing and submitting legislation similar to the osteopath bill of 1935.

In response to the request of the chairman of the Advisory Committee on Conservation of Vision and Hearing, the Board recommended that the Governor be requested to veto S-210, a bill to permit local boards of education to employ licensed optometrists to give vision examinations.

MAY 18, 1952

A regular meeting of the Board of Trustees was held on Sunday, May 18, at Haddon Hall, Atlantic City. The following is a summary of the principal actions taken by the Board at this meeting:

Authorization was granted for a survey of health services throughout the state, to be under the supervision of a special committee consisting of Dr. Sigurd W. Johnsen, as chairman, Dr. C. Byron Blaisdell, Dr. Daniel Bergsma, Dr. Harrold A. Murray, *ex-officio,* and Mr. Richard I. Nevin, *ex-officio.*

Reviewing the legislative activities of the year drawing to a close, Dr. Johnsen stated that the Legislative Committee has done superlative work during the year, but opposition to S-139 lacked effectiveness because of insufficient available information. The Board then approved a recommendation that the Society employ a local attorney to act as confidential legislative analyst to the Subcommittee on Legislation for the ensuing year.

Approval was given to a report of the special committee on Physicians Placement Service, submitted by Dr. Marcus H. Greifinger, chairman.

Approval was given to the nominations submitted by Medical-Surgical Plan of New Jersey for election to its Board of Trustees, with recommendation that the said nominations also be approved by the House of Delegates.

Approval was given to the nominations submitted by Medical Service Administration of New Jersey for election to its Board of Governors, with the recommendation that the House of Delegates also approve the said nominations.

The Board of Trustees accepted, with sincere regret and an expression of profound appreciation of his services to the Society, the resignation of Dr. Henry A. Davidson as editor of The Journal, such resignation to be effective as of June 30, 1952. The matter of

a successor to Dr. Davidson was, upon motion, referred to the Publication Committee for investigation and recommendation.

Approval in principle was granted to the platform of the New Jersey Conference on Federal Affairs, an agency which opposes further encroachment of the federal government in local matters.

A letter from the president of the State Board of Education stating that the appointment of consulting ophthalmologists to the department is entirely a matter of home rule, was referred to the Advisory Committee on Conservation of Vision and Hearing.

A letter from the Commissioner of Education stating that the appointment of an ophthalmologist, as recommended by the Society, will be considered in the preparation of next year's budget, was likewise referred to the Advisory Committee on Conservation of Vision and Hearing.

A resolution approving the fluoridation of public water supplies in New Jersey was approved and referred to the House of Delegates for action.

Approval was given to the recommendation that the 187th Annual Meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City, May 18-21, 1953, and referred to the House of Delegates with a request for its approbation.

A request that the Society study the potentialities of A-492, (a bill which authorizes boards of freeholders operating general hospitals in second class counties to admit paying patients), as involving a threat to the voluntary hospital system, was referred to the Advisory Committee on Hospital Relationships for consideration.

Approval was given to a resolution recommending that "the Society continue to support the activities of Medical Service Administration of New Jersey and continue to designate the director of Medical Service Administration and of Medical-Surgical Plan as its director of the Distribution of Medical Care". The approved resolution was then referred to the House of Delegates.

MAY 21, 1952

The reorganization meeting of the Board of Trustees was held on Wednesday, May 21, at Haddon Hall, Atlantic City. The following is a summary of the principal actions taken by the Board at this meeting:

Dr. Reuben L. Sharp, Camden County, was unanimously elected chairman of the Board for 1952 and 1953.

Dr. C. Byron Blaisdell, Monmouth County, was unanimously elected secretary of the Board for 1952 and 1953.

The Board accepted the resignation of Dr. Vincent P. Butler, newly elected Second Vice-President, as Councilor for the Second Judicial District, effective immediately, and recorded its appreciation of the services rendered by Dr. Butler in the post that he was relinquishing. Dr. Joseph M. Keating, Passaic County, was unanimously elected to fill the vacancy created by the resignation of Dr. Butler.

In accordance with a request of the Commissioner of Health that three names be submitted to the Governor for appointment to the Advisory Council of the Chronically Ill, the Board approved the nominations of Dr. William H. Hahn, Essex County; Dr. Samuel Blaugrund, Mercer County; and Dr. J. Allen Yager, Passaic County. A motion authorizing the establishment of an Advisory Committee on the Chronically Ill was approved.

Approval was given that the special committee on the Medical School be made a special committee reporting directly to the Board of Trustees.

The Board approved a motion that the Second Vice-President, Dr. Vincent P. Butler, be designated chairman of the special committee on the Medical School, and that Dr. Stuart Z. Hawkes be named as vice-chairman of that committee.

A motion authorizing the establishment of a special committee on Medical Research, to report directly to the Board, under the chairmanship of Dr. J. Mallory Carlisle, Rahway, was approved.

The Board concurred in the request of the Medical-Dental Liaison Committee that the chairman of the special committee on the Medical School be named as a member of the Medical-Dental Liaison Committee.

Dr. Luke A. Mulligan, assuming his place as a newly elected member of the Board of Trustees, submitted his resignation as a member of the Finance and Budget Committee. The Board, accepting Dr. Mulligan's resignation, unanimously elected Dr. Joseph I. Echikson, Essex County, to fill Dr. Mulligan's unexpired term.

At this meeting the following new members of the Board of Trustees were introduced: Dr. Vincent P. Butler, Hudson County; Dr. Albert B. Kump, Cumberland County; Dr. Jesse McCall, Sussex County; and Dr. Luke A. Mulligan, Bergen County.

A SPECIAL REQUEST

The Trustees of Medical-Surgical Plan of New Jersey have requested the editor to call the particular attention of members of the Society to the text of the Supplemental Report presented by the Plan to the House of Delegates of the Society at its last Annual Meeting in May 1952. This Supplemental Report, together with the regular Annual Report of the Plan, was unanimously approved by the House of Delegates.

Text of the *Supplemental* Report begins on page 26 of the TRANSACTIONS of the Annual Meeting. The text of the regular Annual Report of the Plan was published in the May 1952 issue of the JOURNAL.

Both reports (particularly the Supplemental Report) contain important factual information concerning recent developments of the Plan which are of immediate and practical interest to every physician.

The attention of our readers is also directed to the informative address presented to the House of Delegates in connection with the Tenth Anniversary observance of Medical-Surgical Plan, the texts of which appear in the TRANSACTIONS.

IN PRAISE OF BERGEN COUNTY

Members of the Bergen County Medical Society, and in particular its Public Relations Committee under the chairmanship of Dr. George M. Knowles, have been widely and deservedly acclaimed for the part that they played in producing the special public health edition of the *Bergen Evening Record* on June 7. That day marked the dedication ceremonies of the nine-story, three hundred and sixty-three bed county hospital at Bergen Pines.

The twenty-two page supplement to the regular Saturday edition of the *Record* tells the stirring story of the growth and expansion of all services and facilities for modern expert medical care in Bergen County through the years. Besides presenting a wealth of descriptive detail about the new hospital, in the pages of the supplement one can read of almost everything of significance, from the establishment of the Bergen County Medical Society in 1854 to the recommended procedure for new county residents to follow in selecting a family doctor, and the proper care to be given accident victims until the doctor arrives. Consequently, this is a compilation that all residents of Bergen County will want to keep at hand for valuable information and ready reference. It is a work of public service and an instrument of good public relations of which all who participated in its preparation may be justly proud.

Indeed, it is a matter of pride and encouragement to all New Jersey citizens that the members of the professions and the people of the county communities, working intelligently and generously together, have been able to achieve such a superlative structure of service. Bergen County has supplied outstanding exemplification of the American way to community health and well-being.

N. J. OPHTHALMOLOGICAL SOCIETY ESTABLISHED

Born on June 29, 1952, a New Jersey Ophthalmologic Society.

Eligible are those members of The Medical Society of New Jersey whose chief medical interest is ophthalmology.

Membership now amounts to 70 physicians.

Applications for membership are obtainable from Dr. A. R. Sherman at 671 Broad Street, Newark 2, N. J.

AMERICAN TRUDEAU SOCIETY

The annual meeting of the Eastern Section of the American Trudeau Society will be held Friday and Saturday, October 31 and November 1, in Philadelphia. Headquarters will be the Bellevue-Stratford Hotel. Members of the Society wanting to present papers are urged to communicate promptly with the Chairman of the Program Committee, Dr. Katharine R. Boucot, 311 Juniper Street, Philadelphia, Pa.

LOCAL LECTURE BY LAHEY

Dr. Frank H. Lahey of Boston will deliver the second Annual Frank C. Henry, Jr. Memorial Lecture, under sponsorship of the Academy of Medicine of Raritan Bay. The lecture to be preceded by dinner, will be delivered October 1, at Oak Hills Manor, Metuchen, N. J.

The subject of Dr. Lahey's lecture will be "Newer Developments in the Treatment of Thyroid Disease". All desiring to attend communicate with the Academy promptly.

The Memorial lectures were inaugurated in 1951 in tribute to the late Chief of Surgery of the Perth Amboy (N.J.) General Hospital.

INTERNATIONAL FERTILITY ASSOCIATION

The International Fertility Association, founded in October 1951, in Rio de Janeiro, announces the World Congress on Fertility and Sterility to be held in conjunction with the American Society for the Study of Sterility in New York in May 1953. This society has been established to study the problems and implications in this field, and to standardize nomenclature, diagnostic methods and therapeutic measures throughout the world.

INDUSTRIAL MEDICINE COURSE

Columbia University announces a series of lectures on Occupational Medicine from nine to ten o'clock on Saturday mornings beginning September 20, 1952. The lectures will be given in Amphitheater A, College of Physicians and Surgeons, 630 West 168th Street, New York. There will be no formal registration and no tuition fee. The schedule is as follows:

September 20—History of Occupational Medicine
September 27—Scope and Practice of Occupational Medicine
October 4—Industrial Toxicology
October 11—Toxic Metals I
October 18—Toxic Metals II
October 25—Toxic Solvents I
November 1—Toxic Solvents II
November 8—Toxic Dusts
November 15—Toxic Gases
November 22—Occupational Dermatoses and Infections
November 29—Ventilation, lighting, noise
December 6—Elementary nuclear physics; radiation hazards
December 13—Workmen's compensation

HORMONE SEMINARS AT N. Y. ACADEMY

"Hormones in Health and Disease" is the theme of the 25th Graduate Fortnight of the New York Academy of Medicine. The program includes panels on Wednesdays and Fridays in the morning and lectures every evening during the two-week period beginning October 6, 1952. For full program, write to Graduate Fortnight, 2 East 103 Street, New York 29, N. Y. Special clinics have been scheduled at 20 New York hospitals each afternoon during the fortnight.

THE UNITED WAY

October is Red Feather month the time each year when health and welfare agencies unite in one campaign to raise money for the continuance of their services.

In towns and cities all over the United States these services for babies and young people, for families, for the ill, the aged and the handicapped are vital to the welfare and happiness of every individual in the community.

Home town needs and national health and welfare programs such as those made necessary by the defense effort are met by *your* contribution to *your* united Red Feather campaign.

Give now, the United Way, for all Red Feather services.

VACCINATION FOR INTERNATIONAL TRAVEL

The World Health Organization has issued a list of vaccinations required in 132 countries from travelers crossing international borders by land, sea or air.

The vaccinations most generally required are against smallpox, yellow fever and cholera. Several countries also specify inoculation against typhoid and paratyphoid fevers, typhus, diphtheria and tetanus.

The requirements specified in the new WHO listing follow the 1944 International Sanitary Regulations which, for most countries, are being applied for the last year. In October 1952 the International Sanitary Regulations of the 1951 World Health Assembly will replace existing international conventions.

Vaccination certificates issued under existing conventions will continue to be recognized by all nations which have accepted them until now, including countries which have already adopted the International Sanitary Regulations.

JOURNAL PRINTER DIES

Mr. Roy F. Hill, the printer of this Journal, died on July 4, 1952. Mr. Hill was the manager of the Orange Publishing Company which printed The Journal of The Medical Society of New Jersey since 1906. This record of publication by the same printer is probably unique in American medical journalism.

The Orange Publishing Company was founded by Frederick W. Hill, the father of Roy F. Hill. The present manager, Mr. Lester R. Hill, is the third generation of the family to print this Journal.

Roy Frederick Hill was born in Newark in 1892. He joined the Orange Publishing Company in 1909 and became manager of the company in 1928. Mr. Hill was a valuable citizen of West Essex, having served on the board of managers of the Orange Savings Bank for fifteen years and having been active in the Orange Rotary Club with 11 years' service as the secretary of that organization.

The Journal has always valued its friendly relationship with the Orange Publishing Company. Over the years this company has become familiar with the personnel and policies of the Medical Society so that the Publication Committee has always thought of the Orange Publishing Company as being almost in the Medical Society's family.

The Publication Committee notes with regret the death of Mr. Hill and extends its sympathy to the bereaved family.

OBITUARIES

DR. EMMA M. RICHARDSON

Dr. Emma M. Richardson, who practiced medicine in Camden for more than 50 years, died in that city on July 3, 1952, at the age of 90.

Dr. Richardson was graduated from the Cooper Hospital School of Nursing in 1891, and received her medical degree from the Woman's Medical College in Philadelphia in 1898. She had been active in civic, club and philanthropic circles, and founded the Mary J. Ball day nursery in Camden. She was an Emeritus Member of the Camden County Medical Society and The Medical Society of New Jersey.

DR. MYRTILE FRANK

Dr. Myrtile Frank, leading physician and former mayor of Egg Harbor, died on July 1, 1952.

Dr. Frank, who had practiced in Egg Harbor for 51 years, was born in France in 1877. He came to this country in 1894 and received his medical degree from the University of Tennessee in 1900. He was a resident physician at Atlantic City Hospital in 1901. He was formerly president of the Egg Harbor Board of Health.

OLD JOURNAL ISSUES WANTED

The Library of Rutgers University, in order to complete its files, desires certain back copies of our Journal. Any member having in his possession any of the following copies, please communicate with the Librarian of Rutgers University, New Brunswick, N. J.: August 1906, October 1906, April 1907 and May 1907.

COUNTY SOCIETY DECALS

Here's an idea for members who want to dress up the new office plaque designed by the American Medical Association to encourage understanding between physicians and patients. Local groups may have decals made up indicating that the doctor is a member of his county medical society. Such a message would show patients that the local medical society is cooperating with the national Association in the campaign for creating better understanding between patients and doctors.

COUNTY SOCIETY REPORTS

CUMBERLAND COUNTY

Frank J. T. Aitken, M.D., Reporter

The regular monthly meeting of the *Cumberland County Medical Society* was held on June 24, 1952, in the Club Room of the Owens-Illinois Glass Company at their Summer Cabins at Palatine Lake, DR. NORMAN W. HENRY of Vineland presiding.

The following applications for transfer to our Society were unanimously approved: DR. JOHN J. BIANCO and DR. MAX EMMANUEL of Vineland; DR. EGAN J. KORICAN of Bridgeton.

DR. HARROLD MURRAY, State President, was introduced. The contemplated medical and dental school for New Jersey was discussed, with its purpose of combating the shortage of facilities for turning out trained personnel, and to improve the standard of medical care for New Jersey residents. Its fruition will be dependent on favorable legislation and the authorization of necessary appropriations approximating five million dollars a year. DR. ALBERT B. KUMP has been appointed as this county's representative for establishing a medical school.

Following the business meeting and an afternoon of sports, an excellent outdoor grilled dinner as the guests of the Owens-Illinois Glass Company and their professional staff concluded the afternoon's program.

HUDSON COUNTY

John L. Varriano, M.D., Reporter

With DR. WILLIAM J. GLEESON presiding, *Hudson County Medical Society* held its annual meeting at Murdoch Hall, Jersey City Medical Center, on May 6, 1952.

DR. JAMES A. WELDON of Bayonne was elected to active membership.

A testimonial resolution honoring DR. GEORGE H. MUELLER, formerly of Jersey City, was proposed by Dr. Gleeson and unanimously adopted.

The following officers were elected: HARRY J. PERLBERG, SR., President; JOSEPH P. DONNELLY, President-Elect; CHARLES L. QUAGLIERI, Vice-President; JOHN P. COUGHLIN, Secretary; ANTHONY J. CONTY, Treasurer; and JOHN L. VARRIANO, Reporter.

DR. SOLOMON SILVER, Associate Physician at Mt. Sinai Hospital and Assistant Clinical Professor of Medicine at Columbia University, presented the guest lecture on "Newer Trends in the Diagnosis and Treatment of Hyperthyroidism, with Special Reference to the Use of Radioactive Iodine".

HUNTERDON COUNTY

John B. Fuhrmann, M.D., Reporter

The annual meeting of the *Hunterdon County Medical Society* was combined with the first annual ladies night, and was held at Ryland Tea Room, Saturday evening, March 29, 1952. More than half of our doctors and their wives were present for a very delicious roast turkey dinner. After the dinner the following officers were elected for the ensuing year:

President — M. W. LOOLOIAN, President-Elect — HENRY DANTZIG, Vice-President — SAMUEL FELDER, Secretary—JOHN B. FUHRMANN, Treasurer—BARCLAY S. FUHRMANN; Delegate to State Convention for three years—V. F. CTIBOR, Alternate—HENRY DANTZIG; Member of Nominating Committee for 1953—L. A. HAMILTON, Alternate—V. F. CTIBOR.

The June meeting of the *Hunterdon County Medical Society* was postponed one week because our speaker was at a convention. The meeting was opened with 70 per cent of the membership present. The president reappointed all committee chairmen to serve for another year. Following this, DR. JOSEPH A. SMITH, Superintendent of the New Jersey State Sanatorium at Glen Gardner gave us a very interesting talk on the present status of the therapy in use in the treatment of tuberculosis.

Following the meeting, we adjourned to the dining room of the Sanatorium and enjoyed a very delightful buffet dinner in conjunction with the members of the Woman's Auxiliary.

MORRIS COUNTY

Albert Abraham, M.D., Reporter

The *Morris County Medical Society* held its annual dinner meeting on June 19, 1952, at Spring Brook Country Club. DR. C. ARCHIE CRANDELL presided. Dr. Voss, Secretary, introduced the physicians who had become members of the society during the past year. Dr. Crandell introduced guests from the Somerset, Warren and Hudson County Societies. He then read a tribute to DR. GEORGE J. YOUNG, who recently retired after serving as treasurer of The Medical Society of New Jersey for the past thirteen years.

Dr. Joseph F. Londrigan of Jersey City spoke briefly of the legislative problems facing the physicians in this state today. Mr. Richard Nevin, Executive Officer of the state society discussed the role of the citizen-physician in every day life, and Dr. Harrold Murray, President of the state society explained the program of the organization.

Dr. Vincent P. Butler of Jersey City, chairman of the committee on the new Medical-Dental School and Health Center, explained the situation as it is presently. Dr. Butler stressed the need for dissemination of information concerning the advantages for the citizens of New Jersey if this educational center should come into being.

The tournament committee distributed prizes to those who excelled in the afternoon golf tournament. There were also several door prizes.

Dr. Earl Stage presented the report of the nominating committee, which was unanimously accepted. The President-Elect, Dr. Theodore Fallmezger, resigned and it was necessary to elect another president.

Those officers elected include: President—FRANCIS J. BENZ, M.D., Vice-President — JACK L. VOSS, M.D., Secretary—ROBERT F. ZIMMERMAN, M.D., Assistant Secretary—DEXTER B. BLAKE, M.D., Treasurer—HENRY O. VON DEILEN, M.D., Reporter—ALBERT ABRAHAM, M.D., Historian—GEORGE J. YOUNG, M.D., Assistant Reporter—ANDREW BREUDER, M.D.

WOMAN'S AUXILIARY

CONVENTION NOTES 1952

Mrs. Stuart Zeh Hawkes, Chairman, Press and Publicity

The 25th Annual Meeting of The Woman's Auxiliary to The Medical Society of New Jersey was held on May 19, 20 and 21, 1952, at Haddon Hall, Atlantic City.

Mrs. Thomas McGlade, President, presided over the Pre-Convention Board Meeting on Monday afternoon. Mrs. McGlade stressed the reorganization of the Auxiliary in Cumberland County. She told of the numerous county meetings she had attended, and suggested that there be a State Nurse-Scholarship so that those counties unable to afford their own might take part in a joint one. The county presidents and the state chairmen gave their reports. Following the business meeting, Mrs. Harold F. Wahlquist, President, Woman's Auxiliary to the American Medical Association addressed the group.

An Auxiliary tea was held in the Rutland Room, honoring the twenty-five years of the Auxiliary's existence and the Atlantic County Auxiliary members. Mrs. Wahlquist was the guest of honor as were the Past-Presidents present, some of whom wore their inaugural hats. Mrs. D. Leo Haggerty read a complete history of the past twenty-five years.

The Annual Meeting was held on Tuesday and presided over by Mrs. McGlade. Following the Auxiliary Pledge and the roll call, Mrs. William E. Dodd conducted a most impressive and sincere service for our deceased members. The Treasurer, Mrs. Asher Yaguda, gave an excellent report. The reports of the President and of the State Chairmen and County Presidents were published in an attractive booklet and handed out to those officers. Among the many highlights were the following facts: the Bulletin increased its rolls by 126 subscribers, Mrs. Haggerty stated that the *News-Note* has an editorial board of eleven members representing the state districts and that it is exchanged with other State Bulletins; Mrs. Bush reported on the reorganization of the Cumberland County Auxiliary and added that Mrs. McGlade has received oral permission to contact Morris County; Mrs. McGlade reported for Nurse Scholarship that there are a total of 54 scholarships; it was reported by Mrs. Voss that 38 new members have joined the Widows and Orphans. In the Presidents' reports several interesting points were brought out. Camden County stressed its Public Relations Heart Problems Day with 317 guests; Mrs. Torppey felt that in Essex the close relationship between the Society and the Auxiliary was most important, also that there have been ten scholarships awarded and that there is a membership of 355; Hudson County had a joint hobby show which was most successful; Mercer County took their health programs to the public and reached 6490 children with their dental health program and 1066 women with their cancer program; Middlesex had an outstanding drug collection drive with over 4½ tons of drugs collected; Passaic feels that their Health Council came into being because of the Auxiliary; Mrs. Tidaback in reporting for Union stated an increase in membership of 37 so that they total 175, and that they collected five tons of drugs; Mrs. Kump, President of the newly reorganized Cumberland County, was proud of their 50 members.

Mr. Richard I. Nevin, Executive Officer of the Medical Society, introduced the morning speaker, Mr. James F. Murray, Jr., the distinguished attorney, lecturer, author and traveler. Mr. Murray spoke on the Mid-Century Challenge to American Democracy.

The luncheon honoring Mrs. Thomas McGlade was held in the Rutland Room following the morning session. The room was gayly decorated with a large 25th Anniversary cake on the platform. Mrs. David B. Allman was the toastmistress and she introduced the guests of honor and the Past-Presidents. Following the luncheon there was a delightful hat show, with the Atlantic County members modeling. Dr. Sigurd W. Johnsen, President of The Medical Society of New Jersey, expressed appreciation for all that the Auxiliary has done and said that now that we are of age the Society will expect more than ever. Dr. Lewis C. Fritts, Chairman of the Advisory Committee to the Auxiliary spoke of the growing importance of the Auxiliary, and said that the Auxiliary work done to defeat the Chiropractic Bill was tremendous.

Mrs. Allman introduced the guest speaker, Dr. Ernest B. Howard, Assistant Secretary, American Medical Association and Advisor to the National Auxiliary. Dr. Howard brought us up to date on some of the A.M.A. programs.

Mrs. Thomas McGlade was next introduced by Mrs. Allman. She said that no task would have been too great with the assistance of Dr. Johnsen and Dr. Fritts. The luncheon was to honor the Past-Presidents and the work of the past 25 years.

Dr. Walter Crist, President of the Camden County Medical Society presented Mrs. McGlade with a gift from his Society.

The Immediate Past-President of The Woman's Auxiliary to The Medical Society of New Jersey, Mrs. R. John Cottone, presented Mrs. McGlade with the Past-President's pin, which is a badge of honor of selfless service.

Mrs. Harold Westcott, President of the Camden Auxiliary presented Mrs. McGlade with a gift.

After the luncheon the General Session was reconvened. Mrs. Stuart Z. Hawkes presented the Essex County Chairman of Publicity, Mrs. Louis L. Covino, with the prize for the most complete scrapbook. In discussing the Chicago Convention it was decided that the delegates go uninstructed to the convention and receive their instructions there. It was stated that there are 1841 active members in the Auxiliary. Mrs. R. John Cottone read the slate of the nominating committee which was unanimously elected, with Mrs. Edward Dyer President. Mrs. Don A. Epler read the resolutions honoring Mrs. McGlade, Dr. Johnsen, Dr. Fritts, Mrs. Edith Madden, Mrs. Harry Subin, Miss Carmela Lorenzo and the Staff of Haddon Hall. The final Credentials Report was that 295 Auxiliary members had registered.

The Inaugural Breakfast was held on Wednesday morning and honored the newly elected President, Mrs. Edward Dyer of Ventnor. Mrs. Dyer's Inaugural Address was published in the July JOURNAL. Dr. Harrold A. Murray, the newly elected President of the State Society was the speaker. Dr. Murray said that we must see to it that every physician and his family gets out to vote. We should assist the Medical Society in its program of medicine and public health and bring their message to other organizations and communities. In our public relations work we should stress the need of a Medical-Dental School in New Jersey. We should study and promote voluntary health insurance, specifically the Medical-Surgical Plan of New Jersey. Following the breakfast, Mrs. Dyer presided at the Post-Convention Board Meeting and instruction of state chairmen by the out-going chairmen.

The Treasurer's statement was submitted by Mrs. Asher Yaguda, and was filed for audit. A balance of $3,849.09 was shown.

Mrs. Robert Walker read the proposed budget for 1952-53, which was unanimously adopted.

Mrs. Salvatore Renney and Mrs. Lloyd Preston of the Woman's Auxiliary to the Delaware Medical Society, were introduced by Mrs. Dyer.

Mrs. Dyer addressed the meeting with the following instructions:

1. All state meetings and State Public Relations Meetings should be noted in booklets published by the county auxiliaries.
2. No politics should enter into auxiliary meetings.
3. Legislative Study Groups should be reactivated.
4. Letters should be sent to organizations in the communities offering them Auxiliary sponsored programs.
5. The county programs for the year should be sent to the State President.
6. County meetings should be conducted in an orderly fashion with proper agendas.
7. Material sent by the State Committee Chairmen should be carefully read, and that which is best for each particular county incorporated in the program.
8. Medical Advisory Boards should be consulted about all activities.
9. Letters should not be sent out to the public without the approval of the Auxiliary President.
10. The Auxiliary should not be represented by anyone without the approval of the Auxiliary President.
11. The President-Elect of the State Auxiliary should be included in all invitations of the counties to the State President.

Mrs. Dyer encouraged all doctors' wives to have their husbands attend county meetings.

There being no further instructions or business to come before the meeting, Mrs. Dyer declared the Post Convention Board meeting and the School of Instruction adjourned.

AUXILIARY REPORT

Essex County

Mrs. Louis L. Covino,
Chairman, Press and Publicity

Mrs. Pascal Baiocchi, President of the *Woman's Auxiliary to the Essex County Medical Society,* held her reorganization Board Meeting at Mayfair Farms on May 26, 1952. Luncheon was served preceding the meeting, at which time all committee chairmen were introduced. Many plans for the coming year were formulated. The Blood Bank at City Hospital will function all summer with our loyal members giving their time to this important program. Mrs. Irving Borsher is chairman.

BOOK REVIEWS

Callander's Surgical Anatomy. By Barry J. Anson, M.A., Ph.D., (Med. Sc.), Professor of Anatomy, Northwestern University Medical School; and Walter G. Maddock, M.S., M.D., F.A.C.S., Elcock Professor of Surgery, Northwestern University Medical School. New 3rd Edition. 1074 pages with 929 illustrations. Philadelphia and London, W. B. Saunders Company, 1952. ($14.00)

The present edition of this excellent textbook of surgical anatomy is the first revision in thirteen years. Because of the untimely death of Dr. Callander, it has been revised and re-edited by Dr. Anson and Dr. Maddock. It was their decision not to change the original pattern of presentation which was so instructive. However, they have added many features not in previous editions and have broadened the scope of the work.

It is interesting in running through the present text to compare it with the edition of thirteen years ago. It brings quick realization of the fact that many new surgical procedures have been initiated in this period of time, and also, many of our concepts have been revised. Most of the sections on vascular surgery are new, and the section on the liver and gall bladder has been expanded.

A great many of the illustrations have been used from current articles to illustrate points in surgical technic, also many illustrations from Dr. Anson's "Atlas of Human Anatomy" have either been added or substituted for less satisfactory illustrations.

Throughout the text the original concept has been maintained of presenting regional and topographical anatomy in such a way as to be most useful to the clinician. The present edition of this valuable textbook, which serves as a bridge between an abstract science and surgical application, is therefore highly recommended, not only to the surgical specialist, but also to those doing occasional surgery.

STUART Z. HAWKES, M.D.

Living in Balance. By Frank S. Caprio, M.D. Arundel Press, 1952. Washington 13, D. C. Pp. 246. ($3.75)

Popularizations of psychiatry continue to flow into the shelves of the book-sellers. Trouble is they all sound pretty much alike. This book, like the hundred others, advises persons to be flexible, to understand themselves, to get proper rest, to control their emotions, to purge the heart of hatred, to seek wholesome recreational outlets, et cetera. All this advice is sound enough, and sometimes a susceptible patient can be inspired by reading it in a book. As with all books of this sort, the dust jacket promises more than the author can deliver. (After reading this book, says the blurb writer, "you can enjoy freedom from tension and worry about domestic and business problems, conflicts of emotion and sexual matters.")

The book covers in readable, and on the whole solid, fashion many facets of modern psychiatry—dreams, alcoholism, suicide, psychoneurosis, and so on. It is, of course, pitched to a dramatic key, probably a necessary device in books of this sort. The physician may find the volume helpful in preparing lectures for the laity. Whether the book should be given to an emotionally disturbed patient is something every practitioner will have to decide for himself in each individual case. This book contains less disturbing material than many other popular texts on psychiatry, but it is bound to add fuel to the introspective fires of any unhappy reader.

WILLIAM SCHRAM, M.D.

Jewish Medicine. Solomon R. Kagan, M.D. Pp. 575. Boston, Medico-Historical Press, 1952. ($10.00)

This new work by an accomplished medical historian, and scholar was written under considerable physical handicap, after the author's serious illness, and retirement from active general practice. This volume is a labor-of-love, the result of much research and great effort over a period of many years. The work contains many informative biographic sketches for the first time. The volume should be in all libraries, for it will be a useful work of reference for physicians, scholars, medical historians, and biographers. Many sketches, and much information contained in this new work by Dr. Kagan, cannot be found in any of the historical volumes now available. The book is highly recommended as an authoritative source of information on the role of Jews and Jewish culture in the history of medicine.

HYMAN I. GOLDSTEIN, M.D.

Surgery and the Endocrine System—Physiologic Response to Surgical Trauma — Operative Management of Endocrine Dysfunction. By James D. Hardy, M.D. 153 Pages with 43 figures. Philadelphia, W. B. Saunders Company, 1952. ($5.00)

The alarm reaction of Hans Selye has had some influence on all fields of medicine. In surgery it has given a teleologic explanation of many phenomena which had previously been accepted on an empirical basis. This book does an excellent job of adapting the newer endocrine concepts to surgery as well as elucidating some of the newer technics in the surgery of the endocrine glands. However, the work suffers from the same unscientific fundamental philosophy that is the weakness of Hans Selye's thesis. Thus the author points out that as a result of the trauma of anesthesia and operations, patients often have oliguria in the immediate postoperative period. Excretion of sodium and chloride is diminished, but rate of excretion of potassium is increased. Since loss of these ions from body is small, low blood levels "may merely reflect a transfer of water from the intracellular to the extracellular compartment. . . . *Therefore, unless and until such electrolytic changes are proved harmful to the organism, it would seem prudent to regard them as purposeful shifts in the*

total response of the organism to stress. Hence it may be more logical to refrain from trying with replacement therapy to bring these serum electrolyte values to normal concentrations in the immediate postoperative period, if these changes are of only moderate degree."

Contrast this with what the author says a few pages later: "the desirability of overcoming the negative nitrogen balance which exists following operations had been questioned by some on the grounds that such nitrogen loss is physiologic. However, the trauma which produced the nitrogen loss was not physiologic and it would seem appropriate to support the injured patients with a diet which at least equals what he would have consumed had he not been injured."

The doctrine of purpose has led the author to eclecticism at its worst. It is high time that in medicine teleology be discarded as it has already been discarded in most of the basic sciences.

In addition to Selye's fundamental philosophical defects, the author has minimized the tremendous role of the nervous system in the control of glandular function and the body as a whole.

HAROLD E. LIPPMAN, M.D.

Rx for Medical Writing. By Edwin P. Jordan, M.D., and Willard C. Shepard. Pp. 112. Philadelphia, W. B. Saunders Co., 1952. ($2.50)

This little manual has a clever title, an uncluttered format, and admirable brevity. But this is the end of the list of virtues. A volume on medical writing which outlines methods of finding a subject about which to write, rather than counselling against adding to the overwhelming mass which floods editorial offices, does not perform a service to the medical public. The chapters concerned with the how, what, and where of manuscript preparation are elementary. The authors violate one of the canons of good writing practice by failing to identify themselves, either geographically or academically, leaving the reader at a loss to know whence cometh the proffered words of advice. The medical student and the neophyte in medical composition will find in this volume an exposition of fundamentals which may be helpful.

SANFORD M. LEWIS, M.D.

Modern Drug Encyclopedia and Therapeutic Index. Edited by Marion E. Howard, M.D. Ed. 5. New York, Drug Publications, Inc. Pp. 1431. 1952.

The practitioner needs a guide through the luxuriant jungle of modern pharmaceuticals. With so many trade-names competing for his attention, so many different ways of packaging the available drugs, it is no longer possible for the physician to remember what trade-name indicates just the combination he wants and how it is packaged and what the dose is. The Modern Drug Encyclopedia comes to his rescue. It starts with a glossary of trade-name generic terms like *Ointlet* and *ophthalet*. Then comes the backbone of the book: more than a thousand pages of pharmaceuticals, alphabetically arranged from Abasin to Zyocel. For each product there is a monograph giving name of the manufacturer, chemical name, description, indications for use, dosage, method of administration and how packaged and supplied. If a non-proprietary name is used (penicillin, for example), all the pharmaceutical companies preparing that product are listed in the monograph.

Next comes a similarly arranged chapter of biologicals, from acne vaccine to Vacagen. Allergens are uniformly treated in the next section. After this is a therapeutic index, where you can find drugs recommended for various syndromes, and also drugs grouped under such functional headings as "absorbents" or "adrenal cortex preparations" or "coronary vasodilators". A unique "generic name index" and an index of manufacturers and distributors complete the volume. Altogether a book that deserves desk top space in any practitioner's office!

ULYSSES M. FRANK, M.D.

A Textbook of Orthopedics. By M. Beckett Howorth, M.D. Pp. 1110. Philadelphia, W. B. Saunders Company, 1952. ($16.00)

Orthopedic surgery has taken giant strides in the last forty years. Progress in physiology, pathology, diagnostic acumen, operative approaches and procedures have made the problem of incorporating this branch of surgery into one book a very difficult one. Howorth, however, tries to do just that. His book is well written, scientifically sound, and of considerable aid in incorporating many new advances. It fails, however, to give as complete a diagnostic work-up as that found in Mercer and fails also to give as complete operative technics and surgical indications as found in either Steindler or Campbell.

The text includes individual chapters written by orthopedists who are experts in special branches of this science. He has selected outstanding subjects to cover these phases. To exemplify the difficulties encountered in trying to cover the field of orthopedics in one textbook, consider surgery of the hand and wrist. Littler, a contributor to Howorth's book, attempts to cover this topic in fifty pages while Bunnell in "Surgery of the Hand" requires over seven hundred pages for the same subject. Another example: tumors of the spine and extremities takes only fifty pages by Howorth. It requires over seven hundred pages by Coley in his "Neoplasms of Bone".

The condensation, however, does not subtract from the value of this book. It can truly be considered a great work for a student or resident in orthopedic surgery or for a general practitioner. It can also be considered a useful review text for the experienced orthopedist.

PHILIP WILLNER, M.D.

The Unipolar Electrocardiogram. By Joseph M. Barker, M.D. Pp. 655. New York, Appleton-Century-Crofts, Inc., 1952. ($12.50)

Since the advent of unipolar electrocardiography, many monographs have appeared on this complex topic. Dr. Barker has ingeniously interwoven in his excellent book not only his own original observations, but also material from all sources including the latest significant information. In the fore-

word, Dr. Frank N. Wilson (whose inspiring teaching led to the writing of this book) says: "To make it as easy as possible for his readers to become familiar with the essential and fundamental principles of his subject, Dr. Barker has himself drawn a large number of diagrammatic figures and has discussed these in detail. He has presented and analyzed many tracings taken on his own patients. These depict not only the more common, but also a great many unusual electrocardiographic patterns. He has made it evident that the interpretation of the electrocardiogram is not merely a matter of memorizing a few characteristic pictures. There are many unusual variations and combinations of electrocardiographic phenomena which must be studied, analyzed and correlated one with another and with other available data before any definite conclusion is possible. These situations demand some acquantance with the electrical and physiological principles by which they are determined. He has presented electrocardiography as a compartment of scientific knowledge that is still expanding. We are beginning to understand something about it, but there is a great deal still to learn. This is as it should be."

The format of the book makes for easy reading with 458 illustrations and 18 chapters plus a bibliography and an index. Although *Unipolar Electrocardiogram* deals primarily with considerations of the ventricular complex, three chapters on the cardiac arrhythmias are included. Dr. Barker has furnished a comprehensive, yet simple, book dealing not only with the unipolar electrocardiogram but with the complete subject of electrocardiography as well.

The author has provided both physician and student with an excellent guide to the basic principles and has established facts and correct interpretation of the electrocardiogram for intelligent correlation with the history, physical findings and other tests in the diagnosis of heart disease.

Edward C. Klein, Jr., M.D.

Diagnostic and Statistical Manual of Mental Disorders. By the Committee on Nomenclature and Statistics of the American Psychiatric Association, Washington, D. C. 1952. Pp. 130. ($1.50)

The search for the ideal nomenclature goes on. It is hard enough in other branches of medicine, but at least there is some general agreement that a lipoma is a tumor and that tuberculosis is due to a specific organism. In psychiatry the task is endless and probably impossible. Who shall say whether mucous colitis is to be classed as a disease of the emotions or a disease of the colon? Where shall one draw the frontier between a schizoid personality and a schizophrenic reaction? The nomenclature which the American Psychiatric Association here offers is the latest effort in this direction. It has been adopted by the American Medical Association, too, and appears also as part of the 4th edition of the Standard Nomenclature of Diseases and Operations.*

This nomenclature represents a radical departure from previous concepts. Up to now, mental disorders fell into four categories: psychoses, neuroses, mental deficiency and personality disorders. In this terminology, however, psychoses of organic origin are torn away from the "psychosis" rubric entirely. Instead they are considered organic disorders with psychotic reactions. The psychoneuroses are broken down into two broad categories—those with chiefly emotional symptoms (which are still called psychoneuroses) and those with chiefly somatic manifestations. The latter are given the unwieldy name of "psychophysiologic autonomic and visceral disorders". Thus, the old fashioned "neurasthenia" is now baptized "psychophysiologic nervous system reaction". The personality disorders bracket is divided into "transient situational disturbances" and "personality disorders" proper. The old "psychopathic personality" is divided into two, one being "antisocial reaction" and the other "dyssocial reaction". There are some novel headings too, such as "gross stress reaction" or "adjustment reaction of late life".

Flexibility is afforded by permitting the examiner to add one of four affixes to almost any other diagnostic term. The affixes are "with psychotic reaction"; "with neurotic reaction"; "with mental deficiency"; and—probably most useful—"with behavioral reaction". All this, and much more, is explained compactly in a 30 page chapter called "Definitions of Terms".

A third chapter deals with the technic of recording terms. It tells how to handle overlapping diagnosis, changes in status, terms indicating precipitating stress, and measures of severity. There is even a numerical conversion from percentage of disability to adjective (20 to 30 per cent disability, for example, is equated to "mild impairment"). This may cause mischief in workmen's compensation and health insurance cases, since the doctor who uses this book, will mean "mild" impairment when he estimates a disability as, say, 25 per cent; whereas in most agencies, 25 per cent goes with a much stronger adjective than "mild".

The *Manual* also includes sections on statistical recording, statistical classification and statistical reporting, with illustrations and examples. Tables for converting this new classification to the older terminologies are also included.

It is customary for book reviewers to say that a certain volume is a "must", or that it should be included in every specialist's library. Such comment would be superfluous here. Since both the A.M.A. and the A.P.A. have placed their imprimatur on this *Manual*, the doctor doesn't have much choice. The private practitioner may adhere to "psychasthenia" or to "Alzheimer's Disease" if he wants to. But as the rising generation of psychiatrists cut their teeth on this *Manual* and only on this, the practitioner who clings to the obsolete terminology will soon be out of date. So here it is, the latest 1952 thought on psychiatric nomenclature. Though more complicated than its predecessors, it is also more realistic and more flexible.

Herbert Boehm, M.D.

* See page 316 of the July Issue of this Journal.

TUBERCULOSIS

ABSTRACTS

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV August, 1952 No. 8

EFFECT OF ISONIAZID ON THE PROGRAM OF THE TUBERCULOSIS ASSOCIATION

By James E. Perkins, M.D., NTA Bulletin, July 1952.

Some of the data concerning isoniazid may be summarized as follows:

Laboratory and Clinical Data. Isoniazid is an easily synthesized chemical which will cost little when released for sale on physicians' prescriptions; it is not patentable, and will be readily available. The drug has been found to be effective against tubercle bacilli in the test tube, and in tuberculous infections in experimental animals, even when there is delay in starting treatment. If treatment is discontinued too early in such experimental animals, relapses occur. Virulent tubercle bacilli have been grown from small, residual pulmonary lesions removed at autopsy of experimental animals, which apparently had recovered following treatment with the drug.

Isoniazid behaves well pharmacologically in man. When administered by mouth in suitable dosage, concentrations of the drug are obtained in the plasma and in the cerebrospinal fluid which are highly effective against virulent human bacilli in the test tube, and yet well below the level of toxicity in experimental animals. Increased appetite, gain in weight, and reduction of fever occurs frequently when patients with far advanced disease are treated with the drug. Changes in the X-ray picture have not been notable in patients with extensive tissue destruction. In cases of miliary tuberculosis, impressive improvement has occurred, including marked clearing in serial chest X-rays. The ultimate benefit in all types of patients awaits further experience.

Isoniazid appears to have advantages over streptomycin and PAS, because it is cheap and of low toxicity, because it is administered by mouth and does not irritate the gastrointestinal tract. From a therapeutic standpoint it may not prove to be markedly superior to the combination of streptomycin and PAS.

Public Health Aspects. The new drug is not a preventive, but only a better method of treatment of a patient who already has tuberculous disease. The effect of chemotherapeutic and antibiotic agents on the prevalence of tuberculosis cannot be predicted from the rapid decline in prevalence of pneumococcal pneumonia following the development of effective chemotherapeutic and antibiotic agents against the pneumococcus. Pneumococcal pneumonia is an acute infection with severe symptoms and signs, and even without specific therapy usually terminates quickly in either death or recovery. Pulmonary tuberculosis is characterized by a symptomless onset, by the development of caseation necrosis and tissue destruction, by chronicity and relapses. Even a greatly improved drug is unlikely to exert a rapid effect on the prevalence of tuberculosis though it may accelerate control of tuberculosis used with other proved effective control measures. There seems to be no reason to assume that the new drug will change the nature of the control program more than did streptomycin and PAS.

There should be an intensification of casefinding procedures. The more effective the treatment of tuberculosis, the more reason we have for finding cases at an early stage. If effective therapy is available it should stimulate better cooperation of the public in casefinding programs.

There has been no reduction in the need for hospital beds for tuberculous patients but rather

the reverse. The average duration of hospital stay has increased, not decreased. Although early cases may have a shorter stay in the hospital, other patients who would have died but for the improved treatment, remain longer. Furthermore, more extensive use of surgical procedures has resulted in greater, rather than fewer, demands upon hospital facilities. Finally, segregation of infectious tuberculous patients in hospitals is necessary to protect others. Many patients continue to be infectious despite prolonged treatment with the new drugs.

There has been no decrease in need for rehabilitation. Here, again, the possibility of shorter periods of hospitalization in early cases, thus reducing the rehabilitation problem, is balanced by the needs of the patients who suffer from a prolonged illness with ultimate recovery.

There has been no reason to decrease the program of reasearch. Streptomycin and PAS, and isoniazid, are not perfect drugs. Research must go on for even better ones. Furthermore, a good *vaccine*, superior to BCG, would have greater potentialities for control of tuberculosis than *any* method of treatment. Social and economic factors, including nutrition, still need study and definition as they relate to the tuberculosis problem.

There has been no reduction in the program of education. Essential to all aspects of the tuberculosis control program is an adequate program of education of the public and members of the medical and allied professions. The need for such an intensified educational program is more urgent in view of the distorted impressions concerning isoniazid acquired by millions of people through the premature sensational reports.

Possible adverse effect of new drug on tuberculosis control program. The new drug could actually prove a step backward if it is used indiscriminately with spread of tubercle bacilli resistant to the drug from these patients to others or if there is an unjustified decrease in funds for tuberculosis control programs with reduction of other effective methods of control.

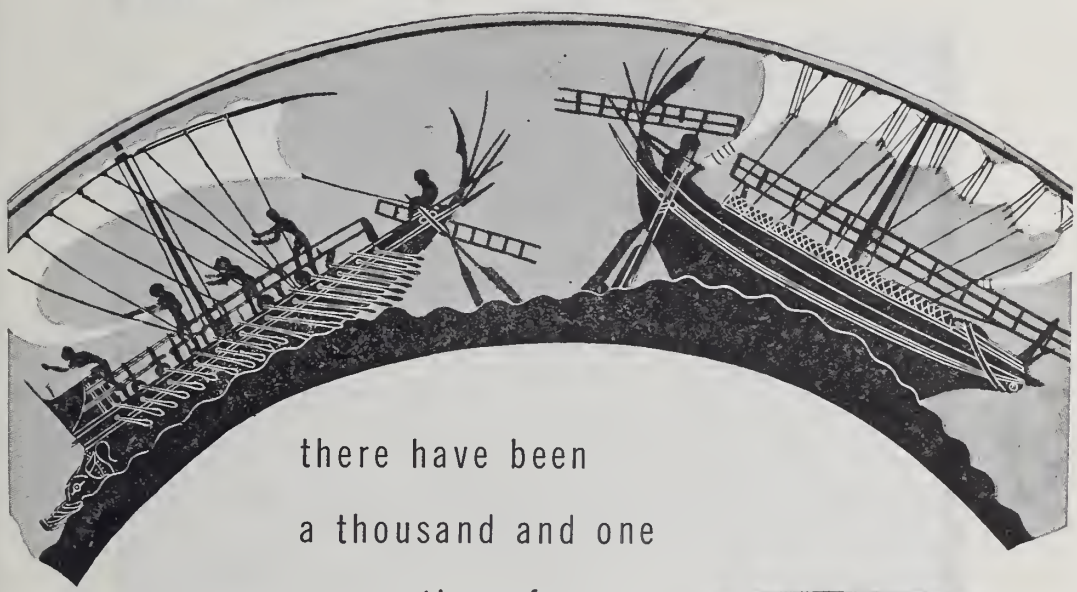
Effect on program of the tuberculosis association. The comments thus far have applied to the tuberculosis control program as a whole. A consideration of the difference between the program of the voluntary agency and that of the official agency shows that with the exception of enforcement of laws and regulations, there is no aspect of the tuberculosis control program, which under appropriate local conditions, cannot be engaged in legitimately by the tuberculosis association, at least on a demonstration basis. The tuberculosis association's special usefulness lies in the field of education, where the tuberculosis association can be particularly effective because it consists of medical and non-medical citizens working as volunteers. Hence, statements from these volunteers to their fellow citizens and their elected representatives carry greater weight than statements from employees of health departments. Tuberculosis associations, therefore, must assume the major role in preventing, on the one hand, misinterpretation of the part the new drug will play in the tuberculosis control program, and, on the other hand, seeing to it that improved methods of therapy are utilized as quickly as possible, within the limits of sound practice.

Some of the ways tuberculosis associations have assumed this role are as follows:

Authoritative statements on the current experimental and clinical evaluation of the drug are issued by the American Trudeau Society, which is the medical section of the NTA, and national, state and local associations see that such statements reach promptly all those who need to be kept currently informed of technical progress. The tuberculosis associations must attempt to get necessary funds restored if a mistaken impression of the value of the new drug has resulted in unwarranted reductions in appropriation. Tuberculosis associations should keep the public currently informed of the true role of the new drug so that [illegible] will support an intensification in the casefinding and other aspects of the tuberculosis control program.

NEW JERSEY TRUDEAU SOCIETY
is the medical section of
NEW JERSEY TUBERCULOSIS LEAGUE
15 East Kinney Street, Newark 2, New Jersey

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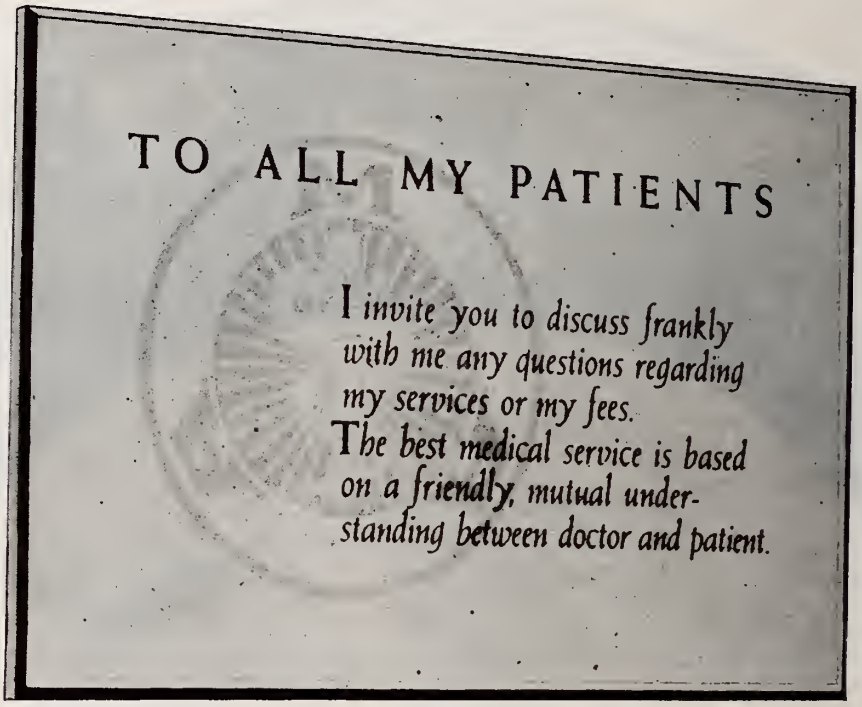
SEARLE RESEARCH IN THE SERVICE OF MEDICINE

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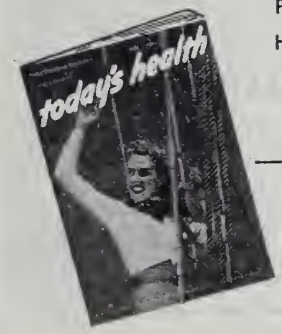
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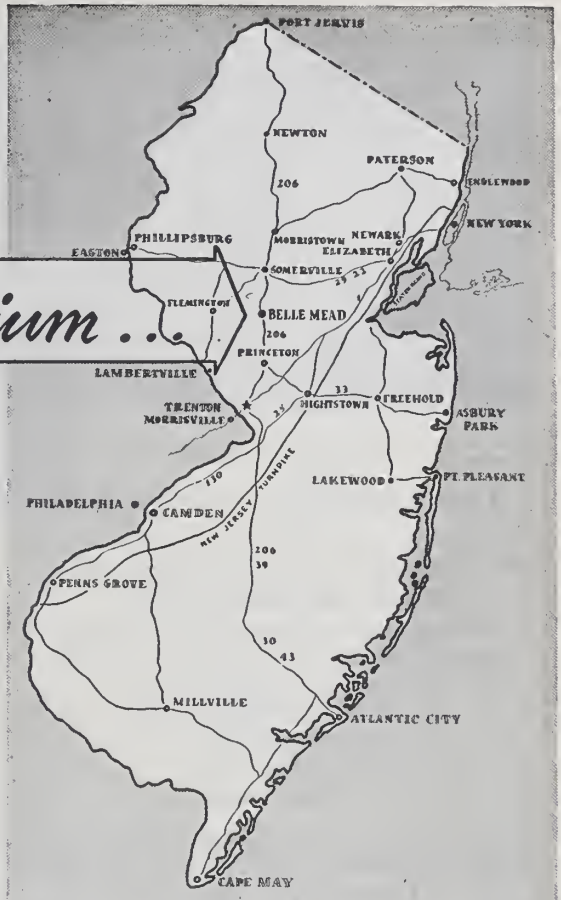
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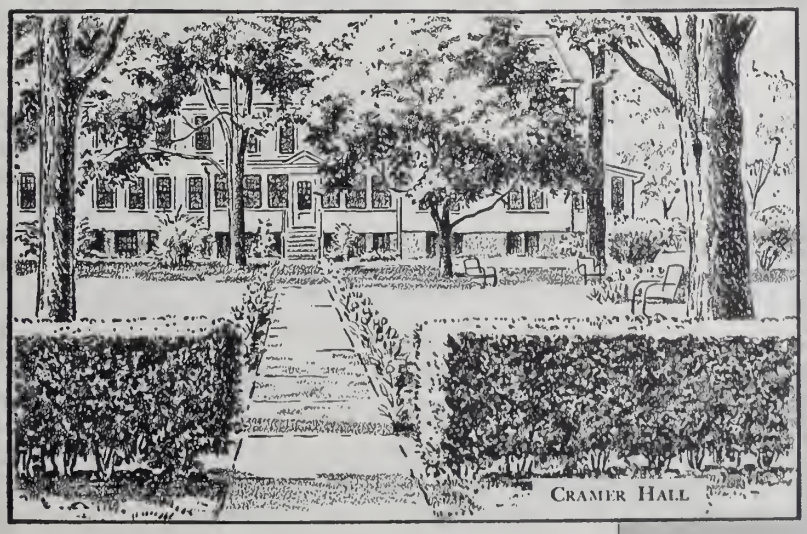
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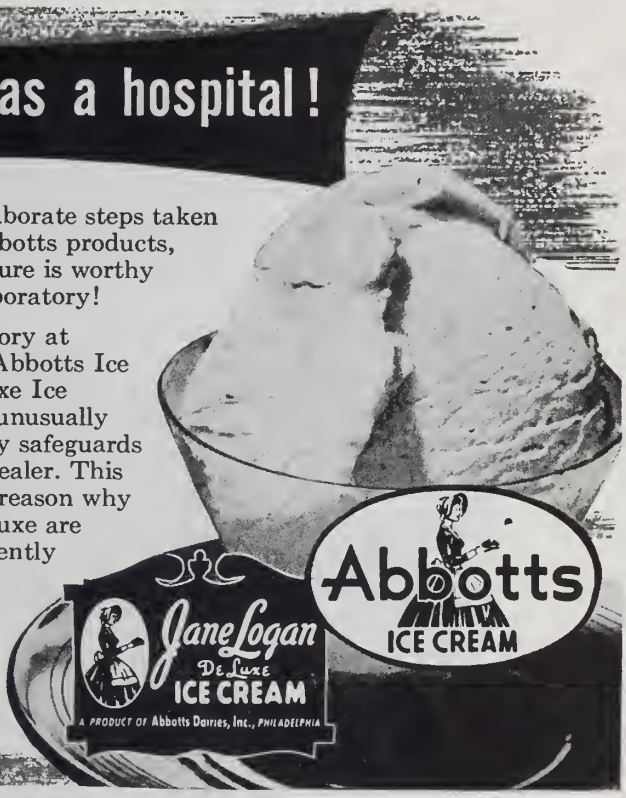


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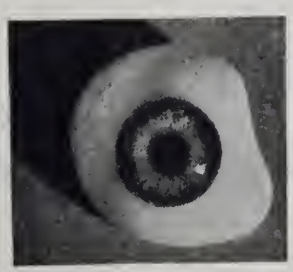
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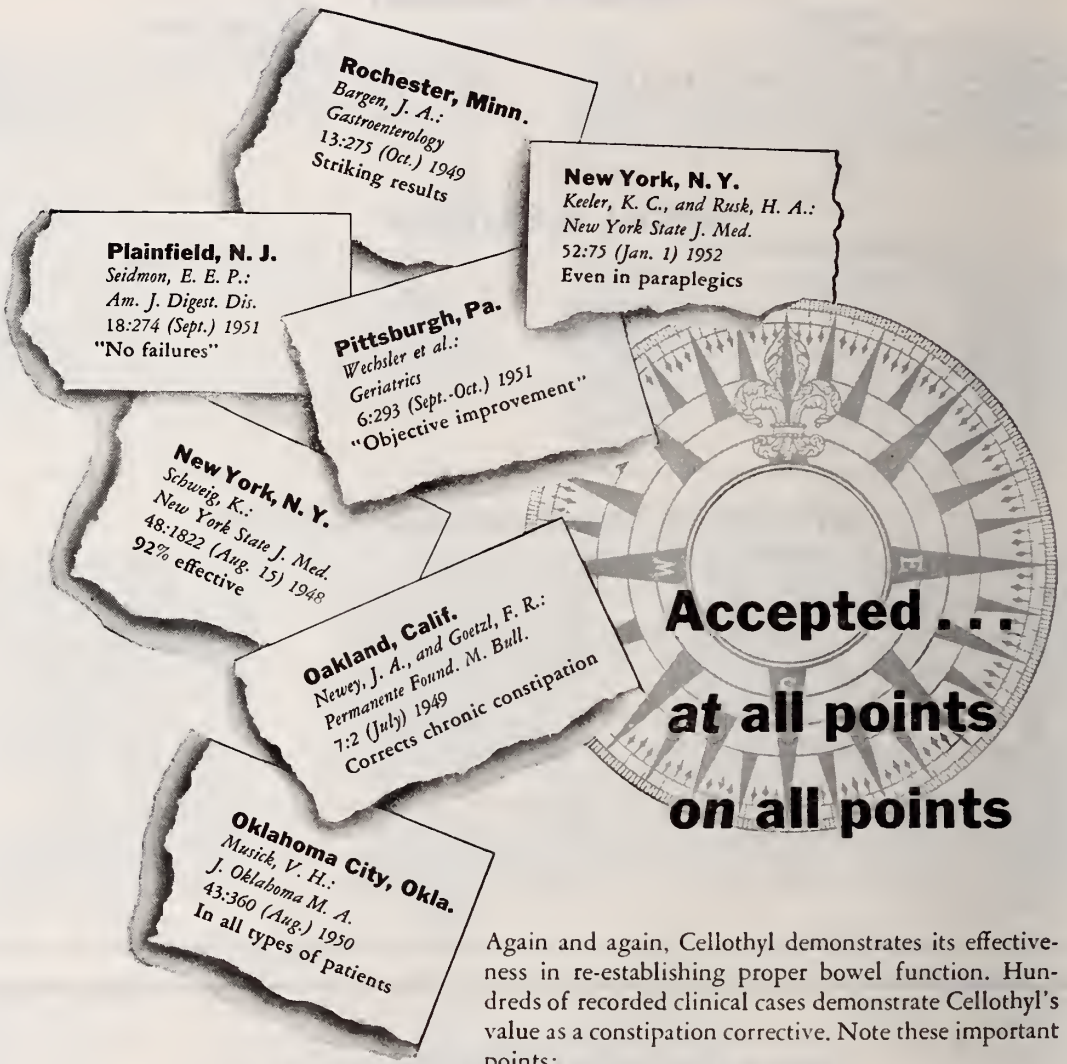
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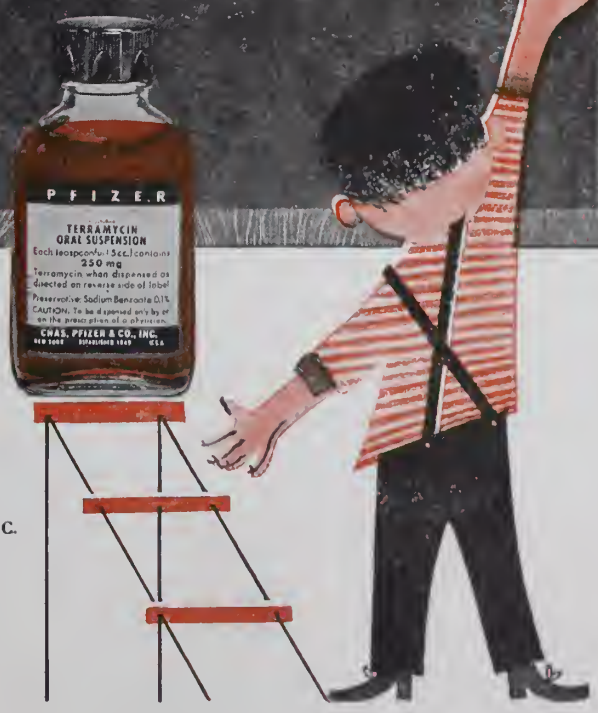
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*Davis, W. D., Jr.: A Critical Evaluation of Therapy in Cirrhosis of the Liver, South. M. J. *44*:577 (July) 1951.

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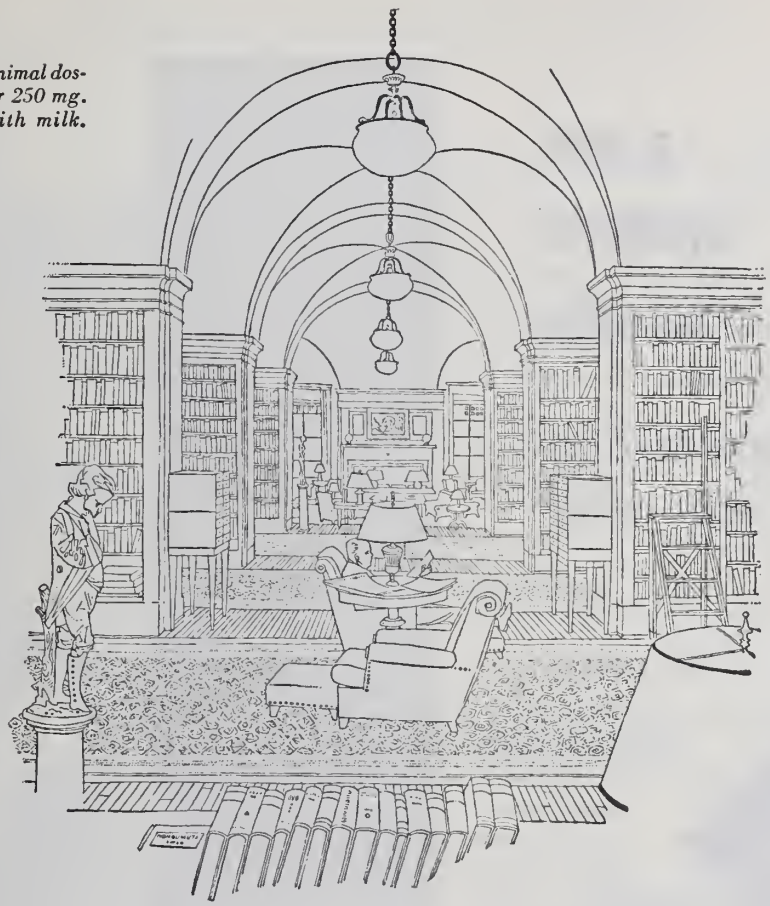
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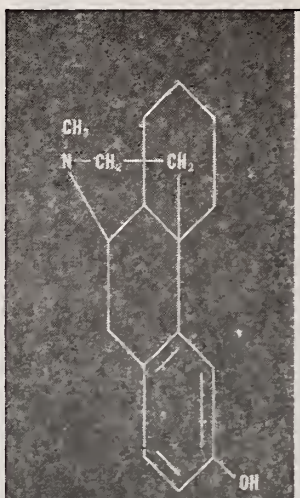
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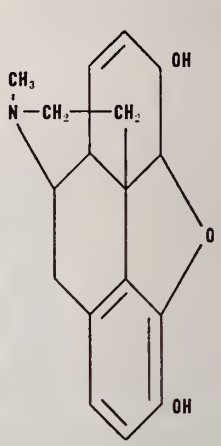
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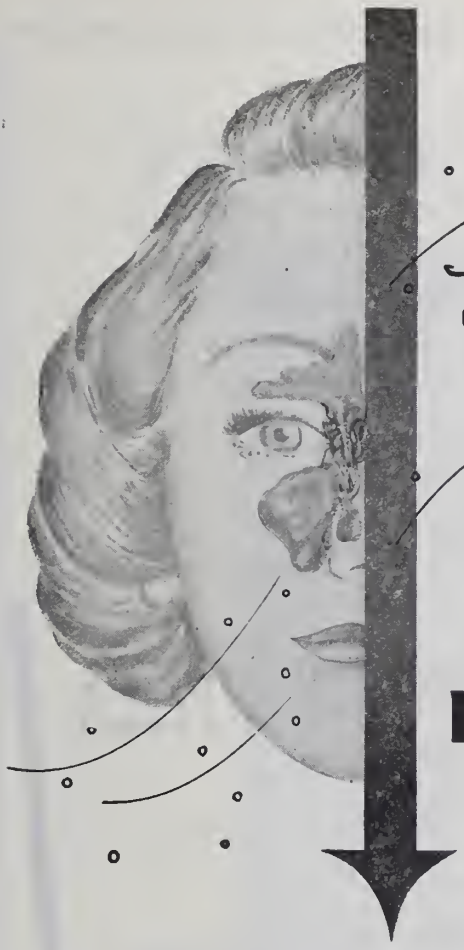
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1. Von Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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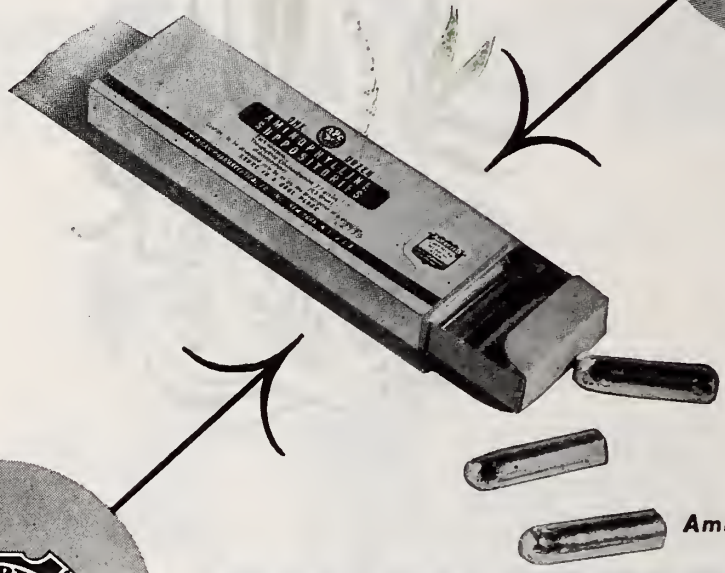
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*Sobel, S. H.: Milk Allergy in a case of Triplets, *Clin. Med.*, August 1952.

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Miriam N. Armstrong,
Assistant Editor

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PRESIDENT'S MESSAGE

OUR ALLIES

It is impossible to conduct adequate and effective programs for the health of our citizens without the active cooperation of everyone who is interested in promoting such programs. This will include our allied professions and many non-professional agencies.

Ranking first is our Woman's Auxiliary. Over the years the members of this gallant organization have been ever at our side. The wives of our members are deeply interested in our welfare and always eager to help us in all our projects aimed at rendering better medical care. They have been untiring in their zeal, and with the associations they have made in the community can be a continuous source of good public relations. One of their most important objectives this year is to see that their busy mates and all their friends exercise the great duty and privilege that is theirs as Americans in voting at the coming election. Every physician and his family must vote in all elections and help insure the health of the community by electing representatives who will be health conscious and whose decisions will not be emotionally swayed by misleading statements of our opponents.

Our allied professions, the dentists, nurses and lawyers will lend a much needed assistance in our positive programs for the welfare of the public. We have established liaison committees with these worthy professional groups which are functioning to our entire satisfac-

tion. Representatives of these organizations attend our various meetings and contribute greatly to the success of our many programs.

A representative from each department in the state government has been appointed as a member or an advisor to the Welfare Committee. The very important Department of Health is represented by our Commissioner of Health who is an active member of the Welfare Committee and attends the meetings of the Board of Trustees on invitation. He will contribute greatly in bringing to fruition many of our programs concerning the health of the public. The Departments of Institutions and Agencies, Labor and many others lend their active support and advice in our many projects.

It was encouraging to witness the large and interested attendance at the first meeting of the Welfare Committee in June. The chairman of that important committee, together with the chairmen of the Subcommittees on Public Relations, Medical Practice, Public Health and Legislation, presented the determined policies for the coming year. These, with the approval of the Board of Trustees, it will be our opportunity as members to implement during this administration. Many important guests were present also to lend their aid. The President of Rutgers University, Dr. Webster Jones, the Provost, Mason Gross, the Commissioner of Labor, Hon. Percy Miller and representatives from all the allied professions were on hand to make constructive suggestions.

We are not alone in our efforts to render the best medical care to everyone within their ability to pay for these services—our allies are ever at our side lending the support that can only spell victory for The Medical Society of New Jersey.

Harrold A. Murray, M.D.

HYPNOTISM FOR EVERYBODY(?)

A course in hypnotism is not part of a medical school curriculum. This is no oversight. It is a deliberate exclusion based on the fact that the technic is too tempting to be entrusted to non-experts. Hypnotism has had a chequered career in the history of medicine. Recently, it has become an object of growing interest, probably because of its official use during World War II. In competent hands, hypnotism proved to be an effective method for treating certain dramatic symptoms that developed out of the isolated traumatic events of a war experience. However, the method is not readily transferred to civilian practice, except for the management of single-symptom disabilities developing out of single-event precipitating factors. For instance, hypnotism, under certain circumstances, might be useful in exorcising a single symptom developing out of a frightening accident. Unfortunately, most civilian psychoneurotics display chronic symptoms rooted in life-long conflicts. This is a syndrome for which, generally speaking, hypnotism is a poor tool. Indeed, there is real danger that, unwisely used, hypnotism may replace minor disabilities with major ones. At best, it merely postpones the time when definitive psychotherapy must be given.

Hypnotism has long been tainted by a faint aura of charlatanism. This is unfair to the many capable and ethical psychotherapists who use it. But the fact remains that it is a technic which lends itself well to incompetent, unethical or commercial hands. Since it can proceed without the use of drugs or surgery it looks to the public as if it is not a branch

of medical practice at all. Courts and regulatory boards often find themselves helpless to prevent hypnotism by unlicensed practitioners, precisely because, on the face of it, it does not look like the practice of medicine. However, the intelligent use of this weapon requires diagnostic study to eliminate structural causes of the symptom, combined with a high degree of professional skill in knowing when to start, when to stop, and how to fuse hypnotism with other forms of therapy. Certainly as a method for treating sick persons, it is a medical technic, the use of which should be limited to doctors of medicine.

THE FREEDOM TO GIVE

We Americans have never been scared of "bigness" as a threat to personal freedom. In the midst of vast economic and social enterprises, we have preserved the vital spark of individualism. It's in our tradition and in our bloodstream.

For that reason we don't get too alarmed by a few people who seem to feel that the big, federated fund-raising campaigns carried on by the Community Chests or United Funds, are somehow a threat to the contributor's freedom of choice in giving to good causes.

How much real freedom of choice does a man have who daily gets a flock of appeals, many of which he knows little or nothing about, but all of which tug at his heartstrings and purse-strings? Seems to us that about all the freedom he has is the freedom to feel like a heel if he turns any of them down, or like a sucker if he gives to all of them.

The fact that a Red Feather campaign includes only the agencies which have been judged by responsible citizens to be doing a good and important job in the community, would seem to be a protection, not a threat to every man's freedom to give.

The fact that contributions are collected efficiently and economically, with the minimum of strain on volunteer giver or volunteer asker, would seem to be an added bulwark to freedom.

Do we condemn a business because it is well managed? Charitable giving is today, in a financial sense, big business—the only big business that deals in millions and gives every cent of profit away. Should it be penalized because it is well planned and efficiently run?

Rather, should we not be proud that at last some of the best business minds are working with some of the most humanitarian hearts to see that the vast flow of our charitable contributions are treated with the dignity and respect they deserve.

That federated campaigns are cool-headed, does not mean that they belittle the warmhearted impulse that must always guide the individual hand to the individual pocket. There is nothing cold about Red Feather services. The contributor knows very well that through his gift, homeless children will find security and love; the sick in body and mind will be healed; the aged cared for; the handicapped restored to useful activity; that families will be helped over hard places; that youth will be guided along paths of growth and self-reliance and good citizenship.

Red Feather contributions are given without strings attached and without the expectation of personal thanks; they are turned into services that bear no label of charity, and can be accepted with no humiliating burden of obligation.

This, after all, is charity in its true meaning of kindness and love, and as we see it, it is well exemplified in the big, the united way of fund-raising.

ORIGINAL ARTICLES

OBSTETRICAL EMERGENCIES *

John N. Connell, M.D., Jersey City, N. J.

There are and will continue to be obstetrical emergencies. Some require prompt and skillful management; but it should never be so hurried as not to be well considered beforehand.

Some seeming emergencies do not require the hasty interference once thought necessary. An example would be moderate bleeding in the last trimester of pregnancy. By moderate I mean episodes of painless bleeding with the passage of 50 to 100 cubic centimeters of blood intermittently. This could be caused by placenta previa or by the partial separation of a normally implanted placenta. It may be difficult to determine the cause without pelvic examination. In the not too distant past, even if bleeding of this character occurred as early as the 30th to 32d week of gestation, the fear of serious hemorrhage (from a central or partial placenta previa) was so great that the patient was brought promptly to the operating room, and a vaginal examination done. Sometimes the examiner, with a long uneffaced and undilated or only slightly dilated cervix to contend with, would come upon a placenta previa. Even the most careful and experienced obstetrician, under these circumstances, might precipitate sudden serious bleeding requiring an immediate cesarean section. Often the baby would be so premature that it would have little chance for survival. This type of bleeding, moderate and occurring many weeks from term, is not the emergent problem it was once considered to be.

These women should be kept in bed with cross matched blood always at hand. Occasionally a transfusion may be required. Often with bed rest and the avoidance of examination they can be brought to a point where the baby has a better life expectancy. Then, if the intermittent moderate bleeding episodes continue, or if serious hemorrhage occurs, the usual current management of placenta previa can be followed. In our hospital† this consists of examination in the operating room with everything set up for a possible section and with at least 1000 to 1500 cubic centimeters of blood at hand. The patient has had her spinal anesthetic, a suitably large needle is well placed in a vein, with glucose or blood running in, depending on circumstances. All this, *before* the vaginal examination. If the patient has a central or partial previa, a cesarean section is done immediately. If it is a marginal placenta previa, simple rupture of the membranes may be enough to permit the baby's head to do well what the Voorhees bag often did poorly. In central or partial placenta previa the most careful vaginal examination may occasionally initiate such hemorrhage that the uterus must be entered, emptied of the baby, placenta, blood and clots, all in a matter of a very few moments, if bleeding is to be quickly and successfully controlled, and the patient survive. The blood must be transfused under pressure in these circumstances to get adequate amounts into the vascular system more rapidly than by the drip method.

In large obstetrical hospitals equipped as they are today to combat it, hemorrhage is no longer one of the leading causes of maternal death. It continues to be a major factor in maternal mortality for the country as a whole and in many large cities. Every hospital with a maternity service must be constantly and adequately equipped to give blood rapidly and in sufficient quantity to combat the sudden and often massive blood loss that may occur in obstetrical patients or deaths will occur that could have been prevented. Blood loss is often underestimated; and of course the amount of

* Presented before the Section on Obstetrics and Gynecology at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1952.

† Margaret Hague Maternity Hospital in Jersey City.

blood loss in proportion to the patient's total blood volume is of most importance. It has long been known, but sometimes forgotten, that saline, glucose, and even plasma can never take the place of blood in the treatment of serious hemorrhage. Maternal mortality reports bear this out. Inefficient and inexpert methods of transfusion must be eliminated. In severe hemorrhage and in hemorrhagic shock, the drip method of transfusion is inadequate. It does not get the blood into the vascular bed rapidly enough. It must be introduced by one of the simple pressure mechanisms added to the regular transfusion set.

POSTPARTUM HEMORRHAGE

Postpartum hemorrhage is the most frequent cause of blood loss in obstetrics. It is important as a direct cause in maternal mortality and just as important as a predisposing cause of serious puerperal infection.

Postpartum hemorrhage is usually due to one of three causes:

1. Uterine atony.
2. Retention of the partially separated placenta, or individual cotyledons.
3. Tears of the tissues of the birth tract.

I will only take up the management of immediate pospartum hemorrhage from uterine atony, because atony is responsible for most of the serious postpartum hemorrhages.

Atony is more frequent in the uterus overdistended by large babies, multiple pregnancies, after prolonged labor, especially if not well managed, and after operative deliveries. Ether anesthesia favors postpartum atony as does mismanagement of the third stage of labor.

At the Margaret Hague Maternity Hospital all three services manage this problem in essentially the same way. Hemorrhage from tears of the birth tract or retained pieces of placenta are quickly ruled out by visual inspection and intra-uterine exploration. The bleeding being due to atony, the entire hand is then placed in the vagina and firm pressure is made against the anterior uterine wall with the back of the closed hand, with counterpressure by the other hand against the posterior surface of the uterus, abdominally. Or the uterus is held abdominally, bimanually up out of the pelvis. This is difficult to do properly in obese patients. Ergotrate[1] is repeated by vein, and Pitocin[2] is used intravenously or intramuscularly. This firm uterine compression is maintained until it is evident that the uterus has attained or regained enough muscle tone to remain contracted. The dangerous aspect of postpartum hemorrhage is that there may be only *minimal* changes in the pulse and blood pressure until large amounts of blood have been lost. Patients can be in a relatively severe degree of shock with normal blood pressure and pulse. When the vascular vasoconstrictor mechanism is no longer able to adapt itself to this continued decrease in blood volume, the blood pressure drops to the low numbers on the sphygmomanometer and the pulse accelerates. The patient then goes into deep and sometimes irreversible shock. For these reasons, as soon as atony is evident or anticipated, a suitably large needle is immediately placed in a vein, if necessary by a quick cut down, and fluid is given. If the estimated blood loss is 500 cubic centimeters or more, a transfusion is started immediately. If the patient was not cross matched, this is done at the very onset of the bleeding; and if cross matched blood is not at hand, Rh negative processed blood is used and introduced into the vein under pressure if necessary. Often postpartum blood loss can be anticipated. In multiple pregnancy, breech presentation, prolonged labor, all forceps deliveries (except outlet forceps) the patient is cross matched early in labor. In the delivery room, a large needle is placed in a vein, and glucose in distilled water is started intravenously. The cross matched blood is held in the delivery room to be used if necessary just as it is in the operating room during cesarean section or gynecologic operations.

This bimanual compression of the uterus, plus Ergotrate[1] and transfusion, will result in a return of tone to most atonic uteri. In some hospitals packing of the uterus is resorted to early in postpartum hemorrhage due to atony. We feel that manual compression is better. The Second and Third Division chiefs

1. Ergotrate is the Eli Lilly and Company trade-name for their brand of ergonovine.
2. Parke, Davis and Company have registered the trade-name Pitocin for their brand of U.S.P. oxytoxic injection.

in our hospital† are vigorously opposed to packing uteri in postpartum hemorrhage under any circumstances. We, on our service, will pack an occasional uterus if the manual compression fails and serious hemorrhage continues even though the organ is firmly held. Under rare circumstances we have manually packed such a uterus and compressed it bimanually until the patient could be taken to the operating room for a hysterectomy. Packing is a temporary expedient, all else having failed, and we do not depend upon it for continued control of bleeding. An occasional hysterectomy will have to be done in these serious cases as a life saving measure.

PERSISTENT TRANSVERSE PRESENTATIONS

The management of persistent transverse presentation depends on the state of dilatation and effacement of the cervix, whether or not the membranes are ruptured and the duration of rupture, the size and shape of the pelvis and the size of the baby. Frequently, in the past (and in some clinics today) where the staff are especially skillful in the performance of internal podalic version, this is the way the problem is often solved. Even with the cervix fully dilated and membranes intact, with no serious pelvic abnormality and a baby of average size or less, the fetal loss has always been high, ranging from 30 to 40 per cent. Even under these conditions the maternal loss in large obstetrical clinics would be from 1 to 3 per cent from rupture of the uterus. Any obstetrical operation today with a maternal mortality of 1 to 3 per cent would be untenable.

In the Margaret Hague Maternity Hospital, because of our unpleasant experience with version and extraction, more women with persistent transverse presentation are being delivered by cesarean section. The results are better for mother and baby. In almost all recent reports on this complication the fetal and maternal results are best with cesarean section if the fetal heart is good before the operation.

Occasionally a patient will be admitted to the delivery floor in active labor with cervix fully dilated, the membranes intact or very recently ruptured, and the baby presenting transversely. Versions are sometimes done in these circumstances; but even here the fetal results are not as good as with cesarean section. A version never should be done in the presence of pelvic contraction or a placenta previa in a transverse presentation; but it is not very easy to estimate pelvic conformation and capacity in relation to the size of a particular baby, once started upon the version.

In our experience, then, persistent transverse presentation in a primagravida at term calls for a stereo x-ray study of the pelvis. With any important degree of pelvic contraction it would be an indication for elective cesarean section at term. Any primagravida with a normal pelvis, who has a transverse presentation at the onset of labor, should be delivered by cesarean section. Rarely with a transverse presentation recognized early in labor, the head can be manipulated to the pelvic brim and held there for a number of contractions and it may then maintain its longitudinal polarity. In multigravidae, whose membranes rupture prematurely and before the cervix is more than five or six centimeters dilated, best results are accomplished with cesarean section. In a review of our recent experiences with persistent transverse presentation, from January 1, 1948, to January 1, 1952, in ten instances it was erroneously diagnosed at the time of rectal examination as a footling breech. In this group of ten, four babies were lost. Because of this, on the First Division of the Margaret Hague Maternity Hospital, all cases diagnosed as footling breeches have to be confirmed as quickly as possible by vaginal examination.

What about the management of a neglected transverse presentation with an arm prolapsed into the vagina, a shoulder impacted in the pelvis, the lower uterine segment thin, a pathologic retraction ring present, and the baby dead? Few problems in obstetrics are more formidable; few obstetricians have done enough destructive operations to be skilled. With ample blood reserves, a good anesthetist, and the operating room set up for a possible hysterectomy, decapitation by means of the sharp hook or sickle knife is the usual operative management. With large shoulders decapitation may be the easiest part of the

operation. With a living baby an extraperitoneal cesarean section would be done. It would not be easy. On the First Division, an extraperitoneal cesarean section was recently done in a case of neglected transverse presentation with a dead baby. We felt that it was safer than a difficult destructive operation.

PROLAPSE OF THE UMBILICAL CORD

Prolapse of the umbilical cord has always been associated with a high fetal mortality although in some hospitals this has been reduced in recent years.

The degree of prolapse, as well as the state of the cervix, are important to fetal outcome. In prolapse, the umbilical cord lies below the inlet and lower fetal pole, protruding into the vagina and sometimes even from the vulva. In partial prolapse, the cord can be palpated below the pelvic inlet but is above the lowest part of the presenting fetal pole. In cord presentation, the cord can be felt through the cervical canal above the inlet.

The incidence is higher in transverse presentations, footling and frank breech presentations. It may occur with the spontaneous or deliberate rupture of the membranes and a high fetal head. It may occur in the course of certain obstetric maneuvers.

Cord reposition may be successful but prolapse usually recurs as soon as the hand is removed from the uterus. Even with successful reposition the fetal loss is high. Braxton Hicks version, manual dilatation of the cervix and bagging, have little place, we feel, in the present day management of prolapsed cord. Cesarean section offers the best chance for fetal survival with a cervix dilated eight centimeters or less and the baby not too compromised. If the cord is pulsating weakly or slowly with the fetal heart rate below 90 or above 160, it is wiser not to hurry into some obstetrical operation that may increase fetal loss. Displacement of the presenting part, Trendelenburg position and anesthetizing the patient with cyclopropane before any attempt at hasty delivery will save some babies by combating the anoxia. If the operating room is set up and rapid cesarean section can be performed, it seems to offer the best method of delivery. In recent years in the Margaret Hague Hospital, very few versions and extractions have been done for prolapse of the cord because of the poor fetal results and danger of rupture of the uterus.

OTHER OBSTETRICAL EMERGENCIES

Some problems are not considered emergencies that truly call for immediate action. In our experience, two obstetrical complications particularly should be thought of as emergencies, at least to the extent of requiring immediate hospitalization and treatment, to prevent very serious consequences. I have reference to women with severe pre-eclampsia and certain forms of rheumatic heart disease. Women have severe pre-eclampsia if their systolic blood pressure is 160 or more and diastolic is 100 or more with proteinuria and edema evident or occult. Too often, even today, we have admitted to the hospital women with eclamptic convulsions, or on the threshold of eclampsia who have had severe pre-eclampsia for weeks at home. A patient with severe pre-eclampsia is as much an emergency as one who has a prolapsed cord or persistent transverse presentation.

Eclampsia should be thought of as a preventable disease. Perhaps it is not entirely preventable and will not be until the cause of the specific toxemia of pregnancy is known. Pre-eclampsia is not entirely preventable. If eclampsia is always preceded by its forerunner, even though the signs are minimal and of short duration, it probably will not be entirely preventable until pre-eclampsia is eliminated.

Although the incidence of eclampsia in our hospital has decreased in the last ten years (and this is probably due to the better prenatal care and alertness of our obstetrical staff and large courtesy staff) the maternal mortality from eclampsia remains at a high figure of 10 per cent. The intra-uterine and neonatal fetal loss has been greatly reduced in the toxemias in the past ten years, and it almost certainly is because of one particular change in management. If a severe pre-eclamptic does not show prompt response to treatment, symptomatic and non-specific as it is, termina-

tion of the pregnancy is the only thing that will cure it with certainty. Even though many of these babies are premature, they have a better chance of survival in a good premature nursery than *in utero*.

About 20 per cent of our eclamptics have never had more than borderline hypertension and 47 per cent were classified as "mild" pre-eclamptics until the convulsion. The safe position is this: A so-called "mild" pre-eclamptic (blood pressure 140 to 160 systolic and 90 to 100 diastolic, with little or no edema and small amounts of protein) might be followed at home for a short time if hospitalization is impossible. Blood pressures and protein determinations should be made daily. If after a short period of observation the "mild" pre-eclampsia does not improve, or if it becomes worse, the patient should be hospitalized as quickly as for any emergency and treated intensively. Too many patients with severe pre-eclampsia are treated at home too long and hospitalized only when they complain of severe headache, visual disturbances, epigastric pain, or nervous irritability. These are the immediate precursors of eclampsia with its maternal mortality of 10 per cent or more.

RHEUMATIC HEART DISEASE IN PREGNANCY

A pregnant woman who has certain forms of rheumatic heart disease is often an obstetrical emergency in that she warrants immediate hospitalization and bed rest sometimes for the duration of the pregnancy. She requires the care of an obstetrician and a very good cardiologist, familiar with this particular problem of rheumatic heart disease complicated by pregnancy.

Deaths from rheumatic heart disease head the list of maternal deaths at the Margaret Hague Maternity Hospital during the seven-year period from January 1944, through 1950. This, too, is the recent experience of other hospitals with similar services. In the Margaret Hague Hospital in this seven-year period, there were seventeen deaths from rheumatic heart disease in pregnancy. Thirteen of these were private patients of the obstetrical or courtesy staff; four were clinic patients; only one was a registered cardiac clinic patient. It has been our experience that the registered cardiac clinic patient with rheumatic heart disease has a much better chance of going through her pregnancy safely, provided she cooperates fully, than the cardiac patient of the private physician whether he is one of the courtesy staff or one of the obstetrical staff. From 1946 through 1950, more than three hundred registered cardiac clinic patients have gone through pregnancy, labor and delivery with one failure and one death. The record of the private patient does not compare with this. Some patients in the private series did not even know that they had rheumatic heart disease. Few received sufficient bed rest. Some had decreasing cardiac reserve for weeks before actual decompensation occurred, but the signs were overlooked or ignored. We feel that a pregnant woman with rheumatic heart disease who has a history of previous failure, or who at any time in the past was a grade 3 or 4 cardiac, should be admitted to the hospital as quickly as any other emergency regardless of the period of gestation and regardless of her present functional capacity. Any pregnant cardiac who is grade 3 or 4 when seen in this particular pregnancy, or whose functional capacity changes in pregnancy, should be hospitalized. It has been our experience, then, that many women with rheumatic heart disease are "emergencies" often weeks before they are actually admitted to the hospital.

CONCLUSION

1. Severe obstetrical hemorrhage is always an "emergency", in that it requires prompt and adequate management, and immediate and sufficient blood restoration. It continues to be one of the leading causes of maternal mortality in the vital statistics of the country at large. In obstetrical hospitals deaths from hemorrhage are, and should be, rare.

2. Cesarean section in some obstetrical emergencies, notably central and partial placenta previa, transverse presentation, and prolapse of the umbilical cord, offer a better outlook for the baby. With the decrease in maternal mortality, it is generally safer for the mother in these complications than delivery through the birth tract. Cesarean section in

these problems accounts for some of the increased incidence of the operation.

3. The toxemias of pregnancy and certain forms of rheumatic heart disease have a high place in maternal mortality reports. These complications should be thought of more frequently as "emergencies", if we are to reduce their very formidable maternal mortality.

DISCUSSION

DR. R. A. MACKENZIE (Asbury Park): Dr. Connell's paper is succinct and practical. I am sure that when this paper is published it will be reread and referred to frequently. Every doctor who practices obstetrics has to face these serious problems and will do so with more confidence because of Dr. Connell's instruction.

Obstetrics is no field for the timid, excitable or impatient doctor. It is not possible and is probably not desirable that every pregnant woman be attended by a specialist. But the steadily improving record of maternal and fetal mortality in our state attests the value of the Maternal Welfare Committee's long campaign for mandatory consultation where unusual conditions develop and for provision of blood and other special facilities in every institution caring for maternity patients. The ideal equipment and abundant assistance enjoyed by all who work at "Margaret Hague" are not matched elsewhere. Many other hospitals in New Jersey have reason to take equal pride in the quality of obstetrical work done there. For this Dr. Cosgrove and his co-workers are responsible in part because they have trained many of those who now staff these hospitals. We have not reached the goal of minimal fetal loss and maximum protection to mothers. But we are working along the right lines. Needed now is a tie-in of gynecologic surgery with the basically surgical obstetrical work of every general hospital for the benefit of both. Only where such combined services exist are communities likely to attract top-flight men or women thoroughly prepared in these joint specialties.

Dr. Connell has properly emphasized *management* of the emergencies selected for discussion. We cannot do much to *prevent* these obstetrical complications—even toxemia. I am impressed by Dr. Connell's conservatism in care of women with antepartum bleeding. But if central placenta previa is quite certain, cesarean section cannot be safely delayed after the 36th week, assuming that the size of the fetus conforms with the estimated development. Premature separation of the placenta is a more dangerous development for the fetus than bleeding from a low implantation. Recently a dramatic case of abruptio placentae with infiltrating hemorrhage and peritoneal exudate gave reminder that the classical signs are not always present to tell the story. This patient was only in the 32nd week of pregnancy. Painless bleeding persisting throughout the day of hospital admission led us to operate and save a baby whose life would certainly have been lost by waiting through the night. Where abruption of the placenta can be diagnosed, action is better than watchful waiting. Choice between puncture of the amniotic sac to induce labor or hysterotomy depends, of course, upon the cervix and other conditions.

With respect to postpartum bleeding, Dr. Connell's scheme of management assumes that the placenta has been expelled or expressed. There are instance of severe bleeding before the third stage of labor is complete. Apparently insignificant oozing can also weaken the patient and create an emergency if the placenta is long retained. Manual removal must be effected promptly when profuse flow occurs and should be delayed not longer than twenty minutes in any case. The difficulty of this procedure varies with the position of the placenta *in utero* and the degree of contraction of the cervix. Inhalation anesthesia is almost always necessary and I dare to speak of chloroform as ideal for the situation. Long anesthesia is not necessary or desirable but good relaxation is most helpful especially if Pituitrin,[3] or Ergotrate[1] have been given coincident with birth of the child. Induction with chloroform (using an open mask held away from the face) is prompt and safe. Recovery is far more smooth than after gas-ether. Need for manual extraction may be anticipated in many cases and injection of morphine and atropine given as soon as the delivery is complete. This medication smoothes the way for general anesthesia if this is necessary. It also quiets the patient during the episiotomy repair under regional block and ensures comfort afterward. Thus a double purpose is served without regret if inhalation anesthesia is not used. It is like having blood typing and preparation for transfusion in cases of protracted labor. One is happy to send the blood back to the bank if it is not given.

Because of recent distressing cases of transverse (shoulder) presentation in one of our Monmouth County hospitals the discussion of this problem by Dr. Connell will be of particular interest to several in the audience. Please note the qualifying adjective "persistent" with which the speaker has defined this emergency situation. Several times each year I am asked by a doctor to see a patient approaching term for the reason that transverse lie of the fetus has been noted and confirmed by x-ray. Complete x-ray evaluation of the pelvis is in order, of course, in every primigravida when the presenting part is in question or the fetal head is not well down in the superior strait. But in these cases, the expense of a so-called flat plate of the abdomen is wasted and the accompanying anxiety of the patient and her family who sense that all is not well is unfortunate. The point is that transverse lie is not uncommon and deserves no attention prior to the final days of pregnancy. It is an altogether different situation when membranes rupture or labor begins and the arm or shoulder (often accompanied by the umbilical cord) attempts to enter the birth canal. Dr. Connell is correct in bringing to attention the difficulty in diagnosing this situation. The breadth of the uterus that one would expect is not always apparent. Breech presentation is frequently assumed. In

3. Pituitrin is the Parke Davis extract of the posterior lobe of the pituitary.

the two cases at the Fitkin Hospital to which I referred, the diagnosis was not made for many hours. Rupture of the uterus occurred in both cases and one patient died. We do not have residents in obstetrics at Fitkin and after this experience we arranged to have each ward patient examined by one of the attending staff upon admission with rupture of the membranes definite or suspected. It has always been my belief and my teaching that digital palpation per rectum is confusing and unreliable unless the presenting part is either a vertex or a frank breech and labor is active. Vaginal examination carefully performed should not contaminate the birth passage. There is much greater danger in permitting labor to continue with uncertain presentation and position of the fetus. As to management of this problem, I differ with Dr. Connell only in that I do not look upon intrauterine manipulation as dangerous in multiparous women with cervix well effaced and membranes only recently ruptured. Satisfactorily deep ether anesthesia is essential. Abdominal section seems unnecessary and undesirable under these conditions with a pelvis that has been proved to be of good capacity.

Concerning prolapse of the cord, it is interesting to note Dr. Connell's advice that no success can be expected by any maneuver designed to repose the prolapsed loop. Although books describe measures supposed to achieve this objective, it has been my experience also that they are not helpful. Decision must be made to intervene quickly choosing cesarean section or version and breech extraction or awaiting the progress of labor without much hope for the infant. One word used by Dr. Connell may have escaped your attention. He advised abdominal section if the condition of the fetus was not "compromised". But the effect of intrapartum asphyxia is so serious that we should hesitate to operate to deliver a child with a very slight chance for normal development. This is my understanding of the significance of the word "compromised". We should be realists and appreciate that not every obstetrical problem has a happy solution. We do a mother no service to subject her to major surgery and burden her whole future with a palsied or otherwise defective child. We must remember too that every section adds something of risk in future pregnancies. While not strictly "emergencies", cases of pregnancy after previous cesarean sections are potentially such. All of us are called upon increasingly to care for women who have had a cesarean delivery for questionable indications in which category I include "fetal distress". In New York, the cesarean incidence approximates 10 per cent in several teaching hospitals. I learned only last week that at one hospital, the ward section rate for the past four months has risen to that figure—equalling that for the private patients. I question whether fetal salvage is better than in New Jersey where the larger hospitals average 3 to 5 per cent cesarean sections. Orange Memorial and Cooper take pride in a cesarean incidence under 2 per cent.

26 Cariton Avenue

OSSIFYING FIBROMA OF THE ETHMOID

WITH CASE REPORT

Arthur Dintenfass, M.D., Leonard S. Ellenbogen, M.D.,
Atlantic City, N. J., and
Matthew S. Ersner, M.D., Philadelphia, Pa.

A case of benign ossifying fibroma of the ethmoid sinus with pre-operative roentgen diagnosis and successful surgical removal is here reported with a brief review of the literature. Purpose of the report is to stress the need for thorough roentgen and otolaryngologic study including direct nasopharyngoscopy in cases of persistent "sinusitis" which fail to respond to the usual treatments or which recur frequently. The case cited was treated for thirteen years for "sinusitis". True diagnosis was not established or suspected until roentgen examination of the paranasal sinuses was performed.* Transillumination is often misleading in sinus disease[1] and for intra-ethmoidal lesions it is completely ineffective.[3]

The fibro-osseous tumors of the paranasal sinuses may be classified as ossifying fibroma, fibrous or spongy osteomas, compact osteomas and diffuse osteomas. According to Fetissof[4] they are distributed as follows: 50 per cent in the frontal sinuses, 40 per cent in the ethmoidal labyrinth, 6.2 per cent in the maxillary sinuses and 3.8 per cent in the sphenoid sinuses.

Most osteomas manifest themselves clinically from puberty to the age of thirty.[5] Onset of symptoms is insidious with a long silent period. Pain and obstructive symptoms due to the growth of the tumor then follow. These symptoms are usually ascribed to "sinusitis". The orbit is the most common cavity invaded

* By Dr. L. S. Ellenbogen.

outside of the sinuses and exophthalmos is the most prominent sign of such extension. It is frequently accompanied by orbital pain and epiphora. Invasion of the dura by these tumors[6] may occur as a late stage and makes complete removal difficult. If the ethmoidal capsule is involved, the middle turbinate may be pushed medially. This not only causes obstructive symptoms but may also cause deviation of the nasal septum.

The diagnosis is readily made by roentgen examination which shows dense tumefaction in a paranasal sinus and which also depicts pressure effects on surrounding osseous structures. This is differentiated from malignant tumors[8] by the absence of destruction or of infiltration of osseous walls.

These tumors usually arise at centers of intracartilaginous ossification.[4] The ethmoidal labyrinth is the site of predilection[5] and many frontal sinus osseous tumors are thought to arise in the ethmoidal cells.[6]

Opinions as to etiology range from the cartilage rest theory of Cohnheim to the thought that the tumors represent granulomas resulting from irritation due to trauma or infection. These tumors could arise secondary to irritation either as the result of periosteal osteoblastic activity or by metaplasia of fibrous tissue into bone. Histologically they appear usually as abnormal bony trabeculae scattered through a connective tissue stroma composed of osteoid rather than adult bone. There is no real bone marrow but rather spaces filled with amorphous tissue in various stages of calcification. However dense osteomas composed of compact bone with a Haversian System and compact lamellae are also found. These tumors are benign and do not metastasize. They may, by virtue of extensive growth and pressure on surrounding vital structures[9] be considered as locally "malignant".

The treatment is complete surgical excision.

CASE REPORT

A 25 year old female was referred February 13 for x-ray study of the sinuses because of severe headaches and right orbital pain of several months' duration. The pain was unaffected by activity or time of day and had been of a continuous nature. She had experienced similar attacks of pain although of less intensity and duration, since the age of 13. These attacks had previously responded to "sinus" treatments.



Figure 1

The roentgen study* was interpreted as follows: There is a well-circumscribed, expanding tumor of bone density occupying the antero-inferior portion of the right ethmoid air sinuses. It measures two centimeters in diameter and causes concave pressure defects on the medial wall of the right orbit and on the medial wall of the ethmoid conchal region extending in the latter direction to the nasal septum. The mass reaches up to the cribriform plate of the ethmoid. There is haziness of the right ethmoid cells behind the mass. The other sinuses are entirely clear and without involvement of their bony walls. There is no roentgen evidence of destruction or of infiltration of the bony walls of any of the sinuses. The haziness of the right ethmoid cells is attributed to obstruction by the tumor mass. *Conclusion:* Ossifying fibroma of the right ethmoid sinus. (See figure 1.)

The patient was referred for study to a rhinologist.† Slight exophthalmos was noted on the right. Examination of the nose showed some pallor of the mucous membranes with slight congestion of the turbinates. The posterior third of the right middle turbinate was in contact with the nasal septum. Palpation of this tissue produced a firm bony sensation. Transillumination of both frontal and maxillary sinuses resulted in normal light transmission. Nasopharyngoscopic examination showed pitting of a mulberry type of the posterior tips of the inferior turbinates and emphasized the prominence

† Dr. A. Dintenfass.

and fullness of the posterior portion of the right middle turbinate.

At operation,‡ March 18, local anesthesia consisting of equal parts of 10 per cent cocaine and one to a thousand Adrenalin[11] was applied topically to the mucous membranes of the nasal cavity and 1 per cent Monocaine[12] was injected as block anesthesia to the infratrochlear, ethmoidal, external nasal and infraorbital nerves.

A semi-lunar incision, 12 millimeters in length, was made on the right side of the root of the nose beginning in the superior portion of the inner canthus of the eye and extending down along the nose. The skin and periosteum were then elevated. The bony structures (consisting of the frontal bone and the frontal process of the superior maxilla) were exposed. With mallet and chisel the frontal sinus and the lateral wall of the nose were opened. The frontal sinus was clean with no evidence of a growth in the frontal region. However, the entire ethmoid capsule was filled with soft mushy bone which felt similar to a cholesteatoma. The tumor involved the orbital plate and could not be removed en masse and was therefore curetted. The resultant cavity was about 25 millimeters in depth, 15 millimeters in height and 10 millimeters in width. The posterior wall of the cavity was opened and found to communicate with the posterior ethmoid sinuses. The periosteum was approximated with number 00000 catgut and the skin was closed with atraumatic sutures.

The pathological report by Dr. A. R. Peale[10] was: "One fragment consists of a mass of dense collagenous connective tissue which supports a few primitive bone spicules. Another section reveals multiple bone fragments separated from one another by bands and islands of connective tissue which is young in type being predominantly fibroblastic. There is no evidence of malignant alteration. Whether this lesion should be called ossifying fibroma or monostotic fibrous dysplasia is open to discussion. The difference is largely academic since the former is considered a variant of the latter. The lesion has an entirely benign appearance." The diagnostic impression was manostotic fibrous dysplasia or ossifying fibroma of the ethmoid. (See figure 2.)

Clinical and roentgen studies over a four year period since operation have shown no evidence of tumor recurrence or of destruction of the osseous walls of the sinuses. The patient has felt well and has been relieved of the severe right orbital pains. The slight bulge of the right eyeball appears to have been corrected.



Figure 2

SUMMARY

A case of ossifying fibroma of the ethmoid sinus in a young woman is described and the literature on the subject briefly reviewed. The need for careful x-ray examination in cases of obscure sinus pain or in cases of apparent sinusitis which do not respond to treatment or which tend to recur is stressed. Such an attempt at early definitive diagnosis may save the patient years of futile therapy with persistence of symptoms especially since routine ear, nose and throat examination (including transillumination) may be normal. A description of the surgical approach to the tumor and of its pathology is given. The patient has shown no clinical or roentgen signs of recurrence in a four year follow-up period.

‡ By Dr. M. S. Ersner and Dr. A. Dintenfass.

1616 Pacific Avenue, Atlantic City, N. J.
1915 Spruce Street, Philadelphia, Pa.

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POLYPOSIS OF THE LARGE BOWEL *

PAUL MECRAY, JR., M.D., and EUGENE H. KAIN, M.D., Camden, N.J.

If all persons over the age of thirty were carefully examined more than ten per cent would be found to have one or more adenomatous polyps of the colon and rectum.[1] The male is more susceptible by the ratio of 3 to 2. The incidence of this lesion becomes more significant when one realizes that *all adenomatous polyps of the colon will eventually become malignant* if sufficient time is allowed to pass.† Seventy per cent of all carcinomas of the colon are found in the lower 25 centimeters of the bowel. In this same region, 71 per cent of all polyps are located. It is no accident that these figures are so nearly identical.

DIAGNOSIS

Sigmoidoscopy should be a part of every complete physical examination. The technic is not difficult to learn. Every general practitioner, every gastro-enterologist and every surgeon should be familiar with it. It requires good positioning, good instruments, suction, a well prepared patient and an operator who will quietly describe to the patient the sensations that he is about to experience.

By means of the sigmoidoscope, the hypertrophied anal papilla with its often pointed tip and whitish color may be seen and its origin observed. The latter will demonstrate that it is not (as it is so often diagnosed) a "rectal polyp". By direct visualization of the adenomatous polyps higher up, a shrewd guess may be made as to whether they are presently malignant. Those smaller than a pea and having the same color as the surrounding mucous membrane are often benign. Those that are larger, sessile, or tending toward a dusky hue may have already undergone malignant change. Adequate biopsy at the time of sigmoidoscopy should settle the problem.

The roentgenologist has difficulty in exploring the rectum, the rectosigmoid, and the lower sigmoid. Above 20 centimeters, however, the skilled roentgenologist, by means of an air contrast enema, can give very accurate information on very minute polypi of the colon. Thus sigmoidoscopy and air contrast studies complement each other. Rarely should one be done without the other.

TREATMENT

The treatment of polyps of the rectum and colon requires great individualization. Histologically benign polyps within the reach of the sigmoidoscope may well be treated by fulgeration. One proceeds as in an ordinary sigmoidoscopy. No anesthesia is required. A special sigmoidoscope with an air exhaust to remove the smoke of fulgeration is most valuable. A fulgerating electrode is used in conjunction with the Bovie apparatus set at about 35. The inactive electrode is placed beneath the patient's bare knee. Experience is required to destroy the lesion completely without perforating the bowel. It is often wise to hospitalize patients with large fulgerations above the peritoneal reflection for signs of perforation or secondary hemorrhage. The latter may infrequently occur as the burned eschar sloughs away.

Malignant polyps above the peritoneal reflection (i.e. approximately 10 centimeters above the anal verge) are best approached transperitoneally. Polyps visualized by air contrast study, but above the reach of the sigmoidoscope, cannot be biopsied. These must be considered malignant and must be so treated. At operation, it is sometimes difficult to locate these polyps when the colon is exposed. It is an aid in identification of the lower lying lesion to sigmoidoscope the patient in the operating room and to place a cotton sponge beside the polyp. At operation, immediately following this pro-

* Abridgement of paper presented before The Medical Society of New Jersey, Atlantic City, May 21, 1952.

1. Jackman, R. J., and Mayo, Charles W.: Surgery, Gynecology and Obstetrics, 93:237 (1951).

† Not all proctologists will agree with this—Editor.

cedure, the sponge and adjacent polyp may be readily palpated. A Cameron light held behind the intestine is sometimes helpful in showing polyps by transillumination. The site of origin of the stalk of the pedunculated polyp is recognized by sliding the lesion up and down within the lumen of the bowel. As the polyp is put on a stretch there is a dimpling at its point of attachment.

Since the introduction of intestinal antiseptics, an additional step has been added. Once the origin of the polyp has been located at laparotomy the bowel is opened at this site. A sterile sigmoidoscope is then passed up and down the colon for direct inspection. It is surprising how much colon can be threaded onto the sigmoidoscope. *In at least one third of the cases, polyps are multiple.*

Once the lesion has been established as being a solitary one, the size, position, and activity of the lesion dictate whether a wedge type of resection or a wide resection with an end-to-end anastomosis is best performed. Where there is a trace of doubt, the resection should be radical.

The most serious problem in treatment is presented in the management of the malignant polyp below the peritoneal reflection. Each case must be strictly individualized. Some may be treated by fulgeration. To this a few surgeons add radon seed implantation. This is technically easy. It has been our experience, however, that if one takes check x-rays every few days one finds that the seeds often move from the nicely ordered pattern in which they were initially placed. The snare cautery is valuable for the pedunculated lesion especially if its stalk shows no invasion. Wedge resections of the rectum are technically possible, particularly if the lesion is low or posteriorly placed. A temporary colostomy may be required in this procedure.

Some surgeons prefer abdomino-perineal resection for all malignant polyps below the peritoneal reflection. This is an excessively radical operation for what may be a carcinoma *in situ*. The overwhelming majority of these lesions may be treated by fulgeration, snare cautery or wedge excision. There remains the occasional lesion which cannot be satisfactorily treated by these means. Here is the one place where the pull-through operation may be indicated. Certainly its indications are uncommon. Dr. R. R. Betancourt and the writers have performed six such procedures. These have been done with two teams operating simultaneously. The procedure has worked well and permits very rapid operating. The results have shown five of the six patients so treated to have excellent sphincteric control. The sixth has, to all intents and purposes, an excellently functioning anal sphincter, but with a minimum of recognition of feces in the newly established rectum.

Needless to say all patients having colonic polyps must be followed with regular periodic examinations for evidence of recurrence or the appearance of new polyps.

DIFFUSE POLYPOSIS

Diffuse polyposis of the colon may be a heredito-familial disease. Twelve years ago we first came in contact with such a family. As far as it has been possible to determine, the great grandfather of the present subjects, died at the age of 29 of cancer of the rectum. The grandfather and his sister died at the age of 36 and 39 from "cancer of the bowel", and "intestinal obstruction", respectively. The mother of our patients had diffuse polyposis known to be present at the age of 42. She was being prepared for colectomy when she suddenly decided against the procedure. She died two years later following the establishment of a colostomy. The sister of the subjects had a total colectomy and an abdomino-perineal resection for polyposis elsewhere. The patients we are describing were first seen in 1939. The boys were then 20 and 22 years old. Both had diffuse polyposis with numerous areas of malignant change when first observed.

These patients were treated by fulgeration of the rectal polyps and ileo-rectal anastomosis followed by total colectomy. In both cases Dr. W. J. Scheffler assisted in fulgerating the polyps in the rectum and lower sigmoid. This was a tremendous task, for it was necessary to destroy 158 polyps in the older boy and 70 in the younger. It has appeared to us wiser to fulgerate the polyps *before* doing the low

anastomosis rather than after the performance of this procedure, as is advocated by most writers. Our technic permits us to work in a dry field rather than in one that is constantly obscured by ileal discharge. It also permits careful fulgeration in the region which will subsequently be the site of the anastomosis. It has the disadvantage that an unnecessarily long area of bowel is cleared, some of which may subsequently be removed at the time of operation.

An error was made in the choice of technic in the first case. In this case the procedure utilized was the operation described by Mayo and Wakefield.[2] An end-to-side ileo-recto-sigmoid anastomosis was created. The entire colon was then resected down to the sigmoid and the distal end of that structure was brought up to the abdominal wall as a nonfunctioning colostomy. This was designed to give a long loop of sigmoid colon for water resorbtion. Through the nonfunctioning stoma, one should be able to fulgerate polyps retrogradely down to the area which has been reached from below. Actually, in our case, the polyps in the unfulgerated area grew so rapidly in the first several weeks after operation and so many of them became obviously malignant that reoperation was necessary. At this second procedure, a resection was performed down to the site of our anastomosis through an area that had previously been cleared of polyps from below. The second patient had an end-to-end ileo-rectal anastomosis and a total colectomy performed in two stages.

Both patients did well and are still free of evidence of disease. Both have two to four semisolid bowel movements daily. Since operation, one of them has had four children of his own. The oldest daughter now thirteen shows evidence of diffuse polyposis this year for the first time. One may guess that in this family, polyps first appear about the age of thirteen; first show carcinoma *in situ* about the age of twenty; and by the age of thirty-five most of the members of the family, if untreated, are dead.

One question, fundamental to the genesis of cancer is raised by this case. To those of us who observed them, there was no question that the polyps were growing and that new ones were appearing. However, once all the areas of polyposis were either fulgerated or resected, no further polyps appeared. In the twelve years which have elapsed since that time, neither patient has shown any further growth. This poses the question: why should this be so?

INFLAMMATORY POLYPOSIS

Polyposis associated with colitis other than ulcerative colitis is rare. A typical patient in this category is a 58 year-old housewife. She had polypoid disease shown pre-operatively and at operation to be limited to the sigmoid colon. A resection of the involved bowel was performed. The mid-descending colon was brought out as a terminal colostomy. The rectosigmoid was mobilized and brought out suprapubically as is done in the first phase of the two stage Lahey abdomino-perineal resection. The specimen was reported as sigmoiditis with multiple inflammatory polyps. The patient was followed for 18 months by sigmoidoscopy through the abdominal anus and the rectum and by air contrast x-ray studies. When, after 18 months, no new polyps had appeared an end-to-end anastomosis was performed. She was last seen three years after the last procedure. There was no evidence of any further disease. Some observers feel that this type of polyposis may occasionally spontaneously disappear.

In contrast, polypoid disease arising in association with chronic ulcerative colitis will show eventual malignant transformation. Fulgeration of the rectum and restoration of the gastro-intestinal continuity (as was described for diffuse adenomatous polyposis) should not be done. Here, resection of the entire colon including the rectum must be performed. Some intriguing operations have been proposed to preserve rectal continence in chronic ulcerative colitis. One such procedure proposes to dissect the mucosa of the rectum from the muscularis. Into the remaining muscular cuff is drawn the ileum, which is sutured to the anal sphincter.

CONCLUSION

Sigmoidoscopy should be utilized as a routine procedure in the examination of patients. One may expect to find polyps in over ten per cent of all persons beyond the age of thirty. By prompt destruction of these lesions, we can reduce the incidence of cancer of the colon, now the commonest cancer in the male and the third most common in the female.[2]

405 Cooper Street

PREGNANCY AND DIABETES *

Alexander Ellis, M.D., Camden, N. J.

Previous to the discovery of insulin, pregnancy in a diabetic woman was infrequent. This was probably due to two factors: diabetic children survived only one or two years; and the diabetic woman of childbearing age was under poor control, and had poorly functioning ovaries with resultant amenorrhea and other menstrual disturbances, with consequent fewer conceptions.

Now the incidence of pregnancy has increased to almost that of the nondiabetic in proportion to the population. Estimates vary from 1 to 1000 to 1 to 500.[2] At the Cooper Hospital, in the last five years there was an incidence of 1 in 800.

MATERNAL COMPLICATIONS

Vascular complications are among the most important. There is arteriosclerosis of the pelvic vessels in diabetes of 10 years or more duration. This results in poor blood supply to the placenta with infarcts as a result of vascular occlusions. Calcification of the vessels is common. This is a contra-indication to pregnancy. *Edema* and *hydramnios* are of common occurrence. They are accompanied by a retention of sodium. A low renal threshold for glucose with a severe degree of glycosuria, even with an almost normal blood sugar, is frequent.

Hypertension and *nephritis* with *proteinuria* are frequent. There is an increased irritability of the uterus with early rupture of the amniotic sac and spontaneous abortion or premature labor.

FETAL COMPLICATIONS

Large edematous babies with evidence of prematurity in spite of the size have been frequently reported. Splanchnomegaly, especially of the liver, spleen and heart, occurs.

Icterus, similar to erythroblastosis, without anemia is common. Swallowing of amniotic fluid with regurgitation into the lungs of the infant during labor must be watched for and treated.

MANAGEMENT

Rigid control of the diabetes is the most important single factor in the management of these pregnancies.

The *diet* should be increased 100 to 300 calories to compensate for the increased metabolism incident to pregnancy. However, in those who are overweight, a lowered caloric intake is necessary. Proteins should be adequate, at least 1½ Grams per kilogram of body weight. This amounts to about 100 Grams of protein daily in the average patient. Carbohydrates, 200 Grams, and fat make up the balance of calories.

Gain in weight should not be over 20 pounds during the entire period of pregnancy.

Insulin is needed in varying amounts. The amount of insulin has to be increased approx-

* Presented at the Annual Meeting of The Medical Society of New Jersey, Section on Metabolism, May 20, 1952.

2. Public Affairs Pamphlet Number 38 (Revised 1951). New York. Public Affairs Committee, Inc.

imately 50 per cent in most cases. After delivery, this usually reverts to the amount needed before pregnancy.

We try to keep the daily loss of glucose in the urine down to 15 Grams and the morning fasting blood sugar below 150 milligrams.

For edema, ammonium chloride, 15 grains, four times daily, with restriction of sodium intake usually suffices. Occasionally we use mercurial diuretics for short periods of time. When these drugs are necessary, care must be taken to avoid hyponatremia.

Smith and Smith[3] in 1933 reported low levels of estrogen in toxemias of pregnancy. This was the basis for hormone therapy.

Ever since the discovery of methods of measuring pregnandiol excretion in the urine by Venning, Browne, *et al.*[4] in 1937, attempts have been made to treat patients with hormones, chiefly estrogens and progesterone. Good infant survival rates have been reported with and without the use of hormones.

White[1] has been one of the chief advocates of stilbestrol and progesterone administration. She reported 83 per cent fetal survival in a series of over 300 cases.[7] She found deficient hormones in 75 per cent of her cases.

Reis, DeCosta and Allweis[5] reported 59 viable babies with 52 living; a fetal survival rate of 89 per cent without the use of hormones.

Crampton, Palmer, Steenrod and Davis[6] had a good comparative series with and without the use of hormones. Better results were obtained in patients who did not receive substitution therapy. Some authorities, in fact, believe that hormones are harmful, and may be responsible for edema of the brain, which sometimes occurs in the fetus.

METHOD OF DELIVERY

There is no unanimity of opinion as to the method of delivery. In our hospital, the obstetricians believe that the contra-indications to vaginal delivery are the same as in the non-diabetic: disproportions between the size of the fetal head and the pelvis, threatened eclampsia, et cetera.

White[1] has most of her patients (approximately two-thirds) delivered by cesarean section.

Hall and Tillman,[2] had 17 per cent cesarean sections while Reis and DeCosta[5] reported a cesarean rate of 56 per cent.

In our series there was only one cesarean in 19 deliveries.

We ask our patients to come into the hospital during the 37th week of gestation, and do a medical induction of labor, if there is no contra-indication to vaginal delivery. This is done to prevent dystocia due to the large size of the baby, which is characteristic of diabetics at full term. It also prevents some of the toxemias which frequently occur during the last 2 or 3 weeks of pregnancy. These toxemias are fulminating and may result in death of the fetus within 24 or 48 hours.

PROCEDURE DURING DAY OF LABOR

During the day of labor or induction, the dose of insulin in the mother is reduced considerably. This is to prevent the hypoglycemia that may take place immediately after delivery. There is a sudden fall in the blood sugar at this time.

If the patient has been taking doses up to 25 or 30 units daily, we omit the insulin entirely for the day. In the more severe cases we give half the usual dose.

The diet is "light" or "soft" and contains the usual amount of calories.

If cesarean section is performed we give a liter of 5 per cent glucose intravenously preoperatively and postoperatively. Insulin is omitted, and then given at four hour intervals according to the amount of glucose in the urine.

CARE OF INFANT

As soon as the baby is born, postural drainage and pharyngeal, and gastric suction are instituted, and repeated in two or three hours. This is to prevent the amniotic fluid (which is swallowed during delivery) from being regurgitated into the lungs.

The infant is placed in an incubator with a continuous flow of oxygen at 6 liters per minute for the first day or two. The treatment is similar to that of a premature baby.

Feeding is begun at the regular scheduled time except in edematous babies, where fluid is withheld or restricted for at least 24 hours. White[7] withholds all fluids for 48 hours. We have not found this necessary, as our babies have not been edematous.

We no longer give glucose parenterally, as the hypoglycemia in the newborn usually does not give any symptoms and is not of importance.

INCIDENCE

During a five year period (1947 to 1951) there were 20 diabetic pregnancies out of a total of 15,966. This amounts to 1 in 800, or 0.13 per cent. See table 1.

AGE OF PATIENT

The ages ranged from 19 years to 42 with a fairly even distribution between 21 years and 40 years. See table 2.

DURATION OF DIABETES

The duration of diabetes was from less than 1 year to 15 years, with most between 1 year and 10 years.

There were two patients in whom the duration of diabetes was unknown. Diagnosis in these patients was made late in the course of their pregnancies. See table 5.

HORMONE THERAPY

Five patients had hormone therapy during the prenatal period. Stilbestrol was given according to the method of Smith and Smith.[3] Biological assays were not done. In one of these there was a neonatal death. Permission for autopsy was not granted. Another was stillborn at 31 weeks of gestation. The fetus was macerated, hydrocephalic and hydramniotic.

This mother had been hypertensive for over 10 years, and was advised against pregnancy.

INDUCTIONS

There were six medical inductions and three by the use of bougie. Four of these inductions were unsuccessful, three medical and one bougie, and therefore recourse was had to rupture of the membranes.

LENGTH OF GESTATION

Length of gestation in these patients was from 28 to 40 weeks. The patient with 33 weeks' gestation had a blood pressure of 184/114, and induction resulted in a spontaneous expulsion of a previable (1 lb. 8 ozs.) macerated hydrocephalic fetus. Table 8 shows the age of the fetus at the time of delivery.

SURVIVAL RATE

There were 3 premature living births and 13 term living infants. One of each resulted in a neonatal death. There were 3 stillbirths, two of which were premature. One stillbirth was in the previable class, and with the correction for this, the infant mortality rate was 4 neonatal deaths or stillbirths in 18 deliveries or a survival rate of 78 per cent. See table 9.

BIRTH WEIGHTS

Among the 19 deliveries, it is interesting to note that there were 18 vaginal deliveries and 1 cesarean section. The indication for the cesarean section was extensive scarring of the vagina and cervix due to a previous extensive vaginal plastic operation with amputation of the cervix. Of the 18 vaginal deliveries, 17 were vertex presentations and one was a breech presentation. This is in sharp contrast to the 10 per cent incidence of breech presentations in diabetic patients reported by Given *et al.* See table 10.

TABLE 1

INCIDENCE OF PREGNANT DIABETICS

Year	No. of Deliveries	Diabetics	Incidence
1947	2,887	2	0.06%
1948	2,986	3	0.10%
1949	3,329	4	0.12%
1950	3,339	7	0.21%
1951	3,425	4	0.12%
Total	15,966	20	0.13%

TABLE 2

AGE OF PATIENT

20 years or less	2
21 to 25 years	4
26 to 30 years	5
31 to 35 years	4
36 to 40 years	4
41 to 45 years	1

TABLE 3

COLOR OF PATIENT

Ratio		Number
89%	White	16
11%	Colored	2

TABLE 4

PARITY OF PATIENT

Ratio		Number
55%	Primiparous	11
45%	Multiparous	9

TABLE 5

DURATION OF DIABETES

Ratio	Years	Patients
15%	Less than 1 year	3
35%	1 to 5 years	7
30%	6 to 10 years	6
10%	11 or more years	2
10%	Unknown	2

TABLE 6

AGE AT ONSET OF DIABETES

Ratio	Age in Years	Patients
10%	Less than 11 years	2
20%	11 to 20 years	4
35%	21 to 30 years	7
25%	31 to 40 years	5
10%	Unknown	2

TABLE 7

DAILY DOSE OF INSULIN

Units	Patients
Diet only	5
1 to 10	1
11 to 20	2
21 to 30	2
31 to 40	1
41 to 50	1
51 to 60	3
61 to 70	1
71 to 80	2
81 to 90	0
91 to 100	1
130	1

TABLE 8

LENGTH OF GESTATION

Weeks	Patients
28	1
30	1
32	1
33	1
34	2
36	2
37	5
38	5
40	1

TABLE 9

SURVIVAL RATES,
18 DELIVERIES (VIABLE)

Living Children	14	78%
Stillbirths	2	11%
Neonatal Deaths	2	11%
Total	18	100%

TABLE 10

BIRTH WEIGHTS

4 lbs. to 4 lbs. 15 ozs.	2
5 lbs. 10 ozs.	1
6 lbs. to 6 lbs. 15 ozs.	2
7 lbs. to 7 lbs. 15 ozs.	3
8 lbs. to 8 lbs. 15 ozs	4
9 lbs. to 9 lbs. 15 ozs.	2
3 lbs. (Neonatal Death)	1
5 lbs. 4 ozs. (do.)	1
7 lbs. 14 ozs. (Stillbirths)	1
3 lbs. (Stillbirths)	1
1 lb. 8 ozs. (Stillbirths Previable)	1

TABLE 11

COMPLICATIONS OF PREGNANCY

Premature Rupture of Membranes	2
Prolonged Labor (over 24 hours)	1
Premature Separation of Placenta	3
Obesity (over 200 lbs.)	2
Hydramnios	5
Pre-Eclampsia	5
Essential Hypertension	2
Insulin Shock	1
Acidosis	1

I wish to thank Dr. Ted Chong, one of our obstetrical residents for his valuable help in compiling the statistics for this paper.

519 Broadway

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SOME CHRONIC PULMONARY DISEASE PROBLEMS IN GENERAL PRACTICE *

SAMUEL COHEN, M.D., Jersey City, N. J.

My purpose is to discuss briefly a few pertinent diagnostic and therapeutic problems of three common chronic pulmonary diseases. The various aspects have been selected for presentation on the basis of their probable importance and interest to many general practitioners. Limited time permits only a most circumscribed presentation.

TUBERCULOSIS

In the realm of *chronic pulmonary tuberculosis,* I wish to refer to two points:

(a) *The significance of the early minimal lesion and the need for prompt treatment:* The early re-infection type of lesion can best be discovered by the chest x-ray film—particularly among apparently healthy individuals. To the general practitioner who sees the patient first or is first informed about the patient via an x-ray report from a health survey, falls the burden of initial orientation of the individual. Frequently there is a tendency to attach little significance to a small lesion simply because of its size and the absence of symptoms.

However, practically every case of far advanced tuberculosis at one time had its inception as an apparently innocent-looking small infiltrate. The best single criterion to judge activity of the minimal lesion is by comparison of frequent periodic chest films. Often the decision can be made on the first film. The factors of age, sex and race are of help in making a proper evaluation. Tubercle bacilli may not be found on smear or culture of the sputum even after many examinations, so that *negative reports do not rule out an active process.* The sedimentation rate frequently is normal in such instances.

A diagnosis of an active minimal lesion must be followed up with prompt therapy which is simple and, in the great majority of cases effective by itself—namely bedrest. It is at this point that difficulties are frequently encountered. If the patient feels well, he has difficulty in accepting the need to make a sudden drastic change from work to rest. The physician is likely to compromise and watch the lesion while the patient continues with his usual routine or reduces his activity to a therapeutically ineffective level. In either event, extension of the lesion is the rule. Treatment then is more time consuming and the outcome less certain.

(b) *The use of antibiotics:* The diagnosis of tuberculosis today is considerably delayed in many patients treated with antibiotics, chiefly pencillin, aureomycin or terramycin, without having the benefit of chest x-ray or sputum examinations. These antibiotics give a false sense of security because of their wide therapeutic spectra. They should be directed at specific infections.

Antibiotics now available for pulmonary tuberculosis have definite limitations. These drugs supplement but do not supplant bedrest, collapse therapy or surgery. Their use must be integrated into a planned therapeutic program which stresses the long range point of view. Chemotherapy should be guided by the specialist in tuberculosis. The temptation to treat all cases with antibiotics should be resisted. Drug treatment is most effective in the relatively recent, fresh exudative bronchopneumonic process or exudative-cavernous lesion particularly following hemoptysis where considerable reversibility of the pathologic process is likely. It is much less effective, or even quite useless in chronic cases with thick-walled cavitation and fibrotic infiltration.

The aim of treatment is to obtain maximum efficacy with minimum toxicity and minimum incidence of development of resistant strains of tubercle bacilli to the drugs used. In the average active case, presenting the indications as mentioned above, this objective is probably best accomplished by the administration of streptomycin 1.0 Gram intramuscularly every third day and para-amino-salicylic acid 12.0 Grams daily

* Read before the Section on General Practice at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 21, 1952.

(orally in 4 divided doses) for 120 days. Such combined chemotherapy for longer periods (up to a year or more) may yield superior results in selected cases. The search continues for non-toxic drugs at least as effective as streptomycin and to which streptomycin-resistant organisms will be sensitive. Considerable interest has been aroused in the past few months by isonicotinic acid hydrazide and the isopropyl derivative. Much more work and time is necessary before these compounds may be properly evaluated in the therapy of human tuberculosis. My personal experience with the former drug began on January 6, 1952, and includes about 50 cases. It is too early to draw any definite conclusions.

CARCINOMA OF THE LUNG

Eighty to ninety per cent of cases occur in males and about 80 per cent in the white race. Sex and race may play some role in the pathogenesis. Reports indicate that bronchogenic carcinoma among men, is second only to gastric cancer. The average patient with cancer of the lung delays hospitalization by about 6 months from the time of onset of symptoms. The onset is insidious in 70 to 75 per cent of cases. In the remainder, the symptoms usually are those of a so-called pneumonia (with or without suppuration) or the outstanding symptoms are already related to metastatic foci. Constant awareness of the high incidence of cancer of the lung and its varied clinical manifestations will increase diagnostic accuracy. But as in tuberculosis, the key to the diagnosis of cancer in its relatively early stage lies in the routine chest x-ray examination particularly in the age group of 40 and over. An abnormal shadow, with or without symptoms, and suggestive of cancer is a sufficient clue for prompt recourse to other diagnostic aids, particularly bronchoscopy. However, negative bronchoscopic examination or negative cytologic examination of aspirated bronchial secretions does not necessarily mean the absence of carcinoma. Exploratory thoracotomy may occasionally be necessary to establish a diagnosis but its primary purpose (for which it should be used more freely) is to determine operability. The only curative treatment today is surgery—pneumonectomy in the great majority of cases and lobectomy in a smaller select group.

Because the group of patients with bronchogenic cancer for which surgery offers no hope of cure is so large, the general practitioner shares in the continued care of these patients. Palliative therapy, not the least of which is psychotherapy, is directed chiefly at relief of pain, control of associated pulmonary infection and maintenance of an adequate nutritional state for as long as possible.

The chief indication for x-ray therapy is to combat chest pain. Methyl-bis, a nitrogen mustard derivative may be useful in some cases but must be administered with care because of its toxicity. Hospitalization during the course of treatment is advised. It is administered intravenously usually in the dosage of 0.1 milligram per kilogram of body weight daily for four consecutive days—one or more courses may be repeated at a later date. Nitrogen mustard may have palliative value in some cases when x-ray therapy is no longer feasible or effective. Most writers express a preference for nitrogen mustard in the presence of superior vena caval obstruction due to metastatic adenopathy. The toxic effects are usually nausea, vomiting and less frequently anemia, leucopenia and thrombocytopenia.

In the later stages, for relief of pain and apprehension, morphine has been the standard drug, although a relatively newer preparation, Dromoran,† has some definite advantages.

Atelectasis and inflammatory changes involving the parenchyma and the bronchi occur distal to the tumor mass and not infrequently one encounters a carcinomatous "abscess". Cough, expectoration, fever, resulting in part from secondary infection, can be reduced with antibiotic therapy—and sometimes accompanied by surprising regression (albeit temporary) of abnormal roentgen shadows.

Maintenance of an adequate nutritional state may be supported for a time with supplementary dietary intake with commercially available protein concentrates and/or fat preparations plus high vitamin dosage. The intra-

† Dromoran is the Hoffmann-La Roche trade-name for a brand of methorphinan.

muscular use of testosterone will help to produce positive nitrogen balance and also a sense of increased well-being.

EMPHYSEMA

I refer to the hypertrophic or obstructive type of emphysema which is a common condition and which all of you see particularly in middle-aged men. I do not include obstructive emphysema caused by a foreign body. You have all run into a therapeutic "dead end" with many of these patients. I present for your consideration the following measures, the application of which may give varying symptomatic relief:

Change to a warm, dry, low altitude climate may be helpful but it cannot be carried out by most patients, because of the serious personal, financial and domestic difficulties that such a decision entails.

Elimination of smoking will reduce the cough and expectoration of the associated chronic bronchitis which aggravates the emphysema.

Reduction in weight of the emphysematous obese patient will help to diminish dyspnea.

Diaphragmatic breathing should be encouraged. The simplest measure is to recommend respiratory exercises which will increase diaphragmatic mobility. Mechanical elevation of the diaphragm, helping to deflate the lungs, may sometimes be achieved with abdominal belts also.

Bronchial spasm of varying degree is present in most emphysematous patients, so that bronchodilator therapy can be of definite value. Aminophyllin may be given either by vein (for acute episodes of dyspnea), by mouth or in the form of rectal installations. Ephedrine-Amytal[1] capsules may also prove helpful. Demerol[2] in the dosage of 50 to 100 milligrams intramuscularly is a valuable anti-spasmodic. Adrenalin,[3] in oil or gelatine, preferably the latter, or the intramuscular use of ether in oil (1 to 2 cubic centimeters) often aid in relieving bronchial spasm. To help liquefy thick secretions, one should not overlook the saturated solution of potassium iodide. Bronchodilators, such as Neo-synephrin[4] or Isuprel[5] given by aerosolization may be particularly effective. The patient can carry out the therapy at home. Changing the bronchodilator drugs from time to time is often necessary to avoid refractoriness.

Exacerbation of cough and dyspnea is commonly due to superimposed respiratory infection. Chemotherapy is indicated. Usually penicillin (50,000 to 100,000 units) several times daily added to the aerosol medication is adequate.

The intermittent use of oxygen for dyspnea or symptoms of cerebral anoxia may be helpful. It is desirable to avoid (if possible) having the patient feel he is totally dependent on the oxygen tank. When oxygen is given, its concentration should be increased gradually starting with one liter per minute and using nasal catheters. The flow can be increased at the rate of 1 liter per minute per day until 6 or 7 are given. If higher concentrations are subsequently warranted by face or tent, tolerance is far better. When this precaution is not observed, delirium or coma may sometimes occur.

Development of chronic *cor pulmonale* and right ventricular failure as a complication, is frequent. Cardiotherapy then becomes necessary.

Addendum: Lantern slides of several illustrative cases were shown.

100 Clifton Place

1. Amytal is the Eli Lilly Company trade-name for amobarbital.
2. Demerol is the Winthrop-Stearns trade-name for meperidine hydrochloride.
3. Adrenalin is the Parke, Davis trade-name for epinephrine.
4. Neo-synephrin is the Winthrop-Stearns trade-name for phenyl ephrine hydrochloride.
5. Isuprel is the Winthrop-Stearns trade-name for isopropyl arterenol hydrochloride.

THE PSYCHIATRIST'S ROLE IN THE GENERAL HOSPITAL *

Daniel H. Stephenson, M.D., Camden, N. J.

Now that psychiatry is coming of age it becomes important to evaluate its function in the place where it can be the most useful: the general hospital. No institution can honestly be called a "general" hospital unless the mind as well as the body of the patient can be cared for. Psychiatrists on the staff of such a hospital have two main functions: to assist in the handling of the emotional problems in patients on the other services; and to organize and maintain a good in-patient department for mild psychoses and severe neuroses in a special ward. For this plan to function at optimum, it is well to have one or more residents in psychiatry on the house staff. Probably, the general hospital of the future will have a full-time staff psychiatrist to take his place beside the pathologist and anesthesiologist. The saving in bed-days gained as well as the money saved may more than equal his salary. Psychiatry is often misunderstood by other doctors on the hospital staff because the workings of the specialty are impossible to demonstrate without adequate personnel. Private practice is so time-consuming that psychotherapists have very little time to spend in the hospital. Psychiatrists suffer another disadvantage in many general hospitals. By contrast with other specialists, whose services are accepted by most people, the psychiatrist cannot be "forced" upon the patient. The ophthalmologist or cardiologist can usually examine the patient without protest. But if the psychiatrist is called, the patient may be openly hostile and rejecting of the whole procedure. Patients sometimes need weeks of preparation before they can accept psychotherapy. It becomes important then for the psychiatrist to show the interns and residents how to prepare the patient for this. If the patient is not "ready" for therapy, we can only ask him to phone for an office appointment on leaving the hospital if he wants help for his problem.

What can a psychiatrist do to augment the services of the other specialties in the hospital? His most important function is to help interns and residents acquire some knowledge of the psychopathology of their patients by better history taking and by closer observation of them as persons rather than as collections of organs. The body is often trying to say what the patient cannot say. I remember a little man who complained of pain in the abdomen. He had all the tests that were humanly possible; and all findings were "normal". I asked him what he thought caused his pain and he said, "My wife. When she comes to see me or talk to me I get this pain in the belly." I asked him why he didn't tell the doctors and he retorted: "Nobody asked me". Medical teaching today still over-emphasizes the patient as a group of organs rather than a person. Too often we see a four-line history followed by requests for some twenty or thirty tests. Equally exasperating is the lengthy history which is devoid of any real information about the patient. Thomas Macrae once said: "We cannot all be Oslers, but we can do our best to follow in his steps. Physicians and students should always make it a rule to learn everything possible about a patient by the use of their own senses and brains." The psychiatric consultation emphasizes repeatedly the advantages of a *dynamic* history over the many useless ones seen on the wards. It means so little when we read that a parent died of an organic disease in such and such a year. But if we find by further questioning that this parent was a severe alcoholic in life, one who philandered and kept the family in poverty, it becomes very important. It would be helpful to know, for example, if the patient witnessed the father's death, and how he reacted to the event in the ensuing months. The advantages of a good history are endless and we could spend many hours describing their value. It is no more difficult to take a good history than a bad one if the doctor can learn to think psychiatrically with the help of a good teacher. The general hos-

* Presented before the Section on Neuropsychiatry at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 19, 1952.

pital is a breeding ground for many emotional ills. Without psychiatric treatment, many of the problems may grow to mountainous proportions. What does a hospitalization do for many patients? It starts a group of fantasies about diseases, operations, and possible mutilations. This is increased by seemingly endless tests without the reassurance of negative findings. Separation of the patient from the security of the family mobilizes further anxiety. This in turn often makes a patient suspicious, and uncooperative with the busy, overworked doctor who then "rejects" the patient. These patients are usually bursting to ventilate their grievances at this time and an understanding doctor can often remedy the situation in a comparatively short listening period.

A factor in hospitalization is "secondary gain"; the chance to avoid the many problems and decisions of the outside world. An example of this is the woman who, after six days of hospitalization (following a slight head injury) was unable to void. She could not raise her head from the pillow because of severe headaches. At my first visit with her, she finally told me that she had deliberately crashed her car to avoid going home to her husband. They were on the verge of divorce. She was "using" her hospital confinement to keep from going home and settling her problems. Neurologic examination was negative and an indwelling catheter was removed. On the following day she was urged to get out of bed and sit in the chair. The next day she left the hospital. A week later she called to tell me her symptoms were relieved and she had separated from her husband. A psychiatric resident performs this function in a general hospital almost daily. It could just as easily be done by the surgical resident or intern with a little training and assurance. Another function of the psychiatrist in the medical and surgical wards is to pick out those emotionally abnormal people who are unable to adjust outside of a hospital and often have histories of ten to fifteen hospitalizations. The time and effort spent on these people by various consultants, as well as the cost of x-rays and other tests is appalling. These persons often need a long stay in a mental hospital or several years of psychotherapy in a clinic. I can think of a patient who, one by one, developed a new symptom after each one was "treated" for any length of time. She had a laparotomy for gall bladder disease which was not present. This was followed by emotionally induced inability to void. Then followed "migraine" headaches, recurrent dislocations of the jaw, sore throat, sore eyes. Finally, when she seemed to have run out of symptoms, she gave herself a dermatitis factitia! Patients of this type should be treated by a psychiatrist for they are too frustrating for any other doctor to attempt to treat.

Another important function of the hospital psychiatrist is to anticipate suicides. No one realizes the quiet desperation of many hospitalized persons until he has sat down and talked to them for a while. The endless search for the relief of symptoms often leads the patient into a state of emotional and monetary bankrupcy with a deepening of the depression. I was once called to see a patient who had just made out his will. If he didn't get relief with this hospitalization, he was going to commit suicide. He was in a genuine depression. Shock treatment was administered. This lightened the depression enough to relieve the immediate suicidal intent. *A suicide threat must always be taken seriously.* Any patient who talks of suicide should be referred to a psychiatrist. You often read an obituary of a suicide which states that patient has been in poor health for some time. In most of these cases, that "poor health" was compounded by, or manifested by, a genuine depression that would have alerted a psychiatrist, though it may have been passed off casually by a psychiatrically unsophisticated general practitioner. There is unquestionably a need for more psychiatric evaluations of the "problem" patients in the general hospital.

Here are some conditions on the wards where a psychiatrist might be of aid. On the *obstetric ward,* the unmarried mother may need help. The patient with pernicious vomiting or the mother who seems unable to "accept" her new baby may also represent a psychiatric problem. Children in the *pediatric* ward with school problems or a history of delinquencies

should have psychiatric consultation. Psychologic testing will often be helpful in these cases. In *medical* wards, cases of ulcerative colitis, peptic ulcer, asthma, hypertension and arthritis should certainly be evaluated from an emotional standpoint. In the *surgical* ward, the patient with a colostomy, or a leg amputation might have trouble adjusting emotionally to his new reality situation. All psychiatrists find many patients who are emotionally disturbed by a breast amputation and more especially by a hysterectomy. They need psychiatric help. The psychiatrist may be able to help the patient with long standing *skin lesions* or, at least, shed some light on their cause. In many of the puzzling illnesses confronting the doctor today, the study of the emotional life of the patient may help in understanding the etiology and in planning the treatment.

The second principal function of the psychiatrist in the general hospital is the creation of a good in-patient service. Emotionally disturbed patients do poorly when subjected to the usual routine of private, semi-private and ward facilities. It becomes important to give them a special environment with the features of a mental hospital plus all measures which will hasten convalescence. These include inconspicuous protective devices at the windows and all the other safety measures required to prevent suicides. It is important to train personnel in the management of these patients. Nurses and attendants should be able to accept the patient's hostilities, verbalizings and negativistic behavior without becoming emotionally involved themselves. Emphasis should be on "permissiveness" to enable the patients to leave the hospital more quickly and start psychotherapy on the outside. An ideal arrangement[1] includes a game room with television, cards, music and other forms of occupational and recreational therapy. Electroshock therapy should be done so that other patients do not witness the procedure. Well suited to the general hospital is ambulatory insulin. This often helps the severe anxiety states with anorexia as well as the alcoholic patient who is being rehabilitated.

Patients for admission to this ward should be carefully screened by the psychiatric staff. A maximum stay of six weeks represents the most efficient use of the facility. The inpatient treatment of emotional illnesses in a general hospital has many advantages. The family will accept it much more readily than in a state hospital or even in a private sanitarium. Another advantage is the fact that commitment papers are unnecessary. This eliminates the family "guilt" about such a procedure. The patient will improve more rapidly in such an environment because of the effects of group socialization and occupational and recreational therapy. The anxiety produced by routine physical examinations and other tests (which occur in other parts of the general hospital) will be eliminated. The psychiatrist is usually nearer the general hospital than he is to public and private mental institutions. He can visit the patient more frequently. It enables him to build up a "positive transference" more readily so the patient will be more willing to continue psychotherapy after being discharged from the hospital. He has ready access to the rest of the hospital staff for consultation. He can order electrocardiograms, x-rays, and even electro-encephalograms and air studies of the brain if a neuro-surgeon is available. Finally the most important effect would be better understanding and improved liaison between the psychiatrist and the rest of the staff.

This is a challenge to all who practice neurology and psychiatry. The psychiatric patient is as important as the surgical or medical patient and has too long been misunderstood and neglected. Such patients *can* be helped. We can cut down the mortality and appalling morbidity in these patients by working with them in the general hospital.

1. Found, for example, at Mt. Sinai Hospital in New York City.

800 Market Street

DIABETIC RETINOPATHY *

WITH SPECIAL REFERENCE TO JUVENILE DIABETES

RALPH SIEGEL, M.D., Perth Amboy, N. J.

The key to better understanding of diabetes mellitus is the study of the juvenile diabetic. Retinopathy is found in a very high proportion of juvenile diabetics. The eye is, therefore, the ideal place to follow the vascular changes. White and Waskow[1] showed vascular disease in 92 per cent of 220 young diabetics studied and noted that retinal sclerosis was the most frequent lesion, occurring in 85 per cent of the cases surviving 15 or more years of diabetes. Deep retinal hemorrhages were seen next in frequency and only in eyes showing retinal arteriosclerosis. This view of retinopathy in diabetes intimately related to atherosclerosis is opposed by a group led by Wagener[2] who contend that the retinal lesions are characteristic of that disease *per se*. Three cases are presented below that illustrate the close association between diabetic retinopathy and vascular changes in young adults and corroborated the findings of White and Waskow.[1]



ILLUSTRATION #1

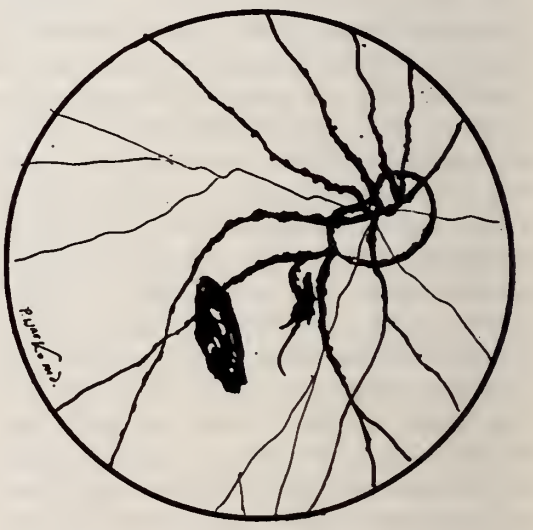


ILLUSTRATION #2

Atherosclerosis of the retinal vascular tree is more frequent in the diabetic group, occurs at an earlier age and to a more severe degree in diabetics than it does in non-diabetics. The development of vascular lesions independent of the severity of the diabetes suggests that the metabolic disturbance which accelerates atherosclerosis is *not* an insufficiency of insulin. In some cases, evidence of disturbed venous and capillary circulation is even more striking than that of atherosclerosis. Distended veins and "micro-aneurysms", are peculiar to the retina, and are not found elsewhere. In the three cases described here there were localized venous thrombi with adjacent hemorrhage into the retina. Fibrosis with progression into retinitis proliferans and retinal detachment as occurred in Cases One and Two is the greatest ophthalmic hazard of the young diabetic today. See Figure 1.

Ashton[3] correlated the retinal and renal lesions in 100 per cent of cases and found that 58 per cent of retinopathy cases had Kimmelstiel-Wilson's[4] disease and that the latter was always accompanied by retinal micro-aneurysms. See Figure 2. This emphasizes the im-

* Read May 20, 1952, at the Annual Meeting of The Medical Society of New Jersey, Section on Metabolism.

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2. Wagener, H. P.: Retinopatby in Diabetes Mellitus. Proc. Am. Diabetes Assn., 5:203 (1945).
3. Ashton, N.: Vascular Changes in Diabetes. Brit. J. Ophth., 33:407 (July 1949).
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portance of edema and protein catabolism in the pathogenesis and metabolism of diabetes, since these two findings together with diabetic retinopathy constitute the three salient features of Kimmelstiel-Wilson's disease.[4] The diagnosis can be made during life and is increasingly common in young adults with mild diabetes of 10 or more years' duration. The typical lesion consists of masses of hyalin which were originally described as intercapillary but are now believed to be of capillary origin. The invariable finding of diabetic retinopathy in these cases supports the idea that there is a general metabolic disorder which leads to hyalin and lipoid changes affecting primarily the capillaries. Hypertension was not a conspicuous feature in the cases presented herein. Siegal and Allen[5] pointed out that a number of their patients with Kimmelstiel-Wilson's disease (proved by autopsy) revealed no evidence of hypertension.

Retinal edema was a high-light in every patient in this report. This was associated with edema of the extremities, face and upper eyelids. The edema is nephrotic in origin and is a watery accumulation of low protein content. In Case One there was fluid in the left pleural cavity. The edema is accompanied by a low serum albumin and a proteinuria. The hypoproteinemia exerts a metabolic effect which leads to edema and in some way may be responsible for the focal hyalinization of retina and capillaries. Since this type of edema is potentially reversible in its early stages, hope in successfully treating diabetic retinopathy is not impossible. However, similar chemical alterations in other conditions are not accompanied by diabetes.

The exudates characteristic of diabetes occur in the posterior polar area, are hard in appearance with sharp edges and may coalesce. They are believed to be hyalin masses in the internuclear layer behind the retinal vessels. These exudates and the hyalin found in Kimmelstiel-Wilson's disease stain red with the Hotchkiss-McManus method and eventual analysis of this material may be a clue to the etiology. It is known that patients with diabetic retinopathy have an increased capillary fragility. Barnes[6] in a study of 220 patients reported that after giving rutin in daily doses of over 300 milligrams for 18 to 30 months there was little effect in improving either capillary fragility or diabetic retinopathy. In retinal hemorrhages, therefore, factors are at work other than the capillary weakness. Furthermore, there is no proof that increased capillary fragility of skin capillaries is accompanied by a similar fault in the retinal vessels. Givner[7] noted that several patients had retinal hemorrhages during the course of rutin therapy.

CASE ONE

A female, aged 22, was admitted to the Perth Amboy General Hospital on December 25, 1951, with complaints of blurred vision and swelling of the face and extremities of three weeks' duration. This was followed by persistent cough and fever. There was a seventeen year history of diabetes mellitus. She had a marked edema of the face, upper eyelids and extremities. Respirations were rapid and accompanied by non-productive cough. There was a large ulcer of the left lower extremity and feeble dorsalis pedis pulsation. The eye findings showed marked retinal edema, advanced atherosclerosis and venous distention. The right superior temporal vein was irregularly beaded, and there were adjacent blot and punctate hemorrhages. In the right eye there was a ring pattern of hard exudates just temporal to the macula. The left eye already manifested retinal detachment, a horseshoe tear below the disc and neo-vascularization.

The laboratory findings were as follows: Urine-albumin 4 plus; sugar 0 to 2 plus; acetone faint trace; leucocytes and amorphous crystals in the sediment. Blood-sugar 104 to 394; N.P.N. 43; creatinine 2.1; total protein 5.5; albumin 2.9; globulin 2.6; cholesterol 258; carbon dioxide combining power 40 volumes per cent; blood acetone 0. Capillary fragility-markedly increased; electrocardiogram showed myocardial damage; x-ray of chest on admission was read as bronchopneumonia. On repetition several days later this had cleared up and there was residual fluid at the left base. Blood pressure was 124/70.

The course was rapidly down-hill. The leg soon became gangrenous. Insulin requirement was not diminished, signs of acidosis were slight. Heparin had no influence on the course of the vascular occlusions. A sympathectomy was urged by a consultant and the patient was transferred to The New York Hospital on January 20, 1952, where a lumbar puncture was done on admission. The patient died shortly after the spinal tap. Postmortem examination was not granted.

5. Siegal, S., and Allen, A. C.: Intercapillary Glomerulosclerosis and Nephrotic Syndrome in Diabetes Mellitus. Am. J. Med. Sc., 201:516 (April 1941).
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CASE TWO

A male, aged 30, presented himself with a history of blurred vision in the right eye of one week's duration and blurred vision in the left eye which had been present for eight months. He had had kidney trouble one year previously with swelling of the extremities and albumin in the urine. There was an eighteen year old history of diabetes and conscientious control. He showed puffiness of the face and marked edema of the upper lids. Vision in the right eye was 20/40 and the outstanding retinal signs were beading of the veins and capillary micro-aneurysms plus retinal edema. Blood sludging was noted in the right superior nasal vein which preceded the onset of the aneurysmal dilatations. Localized thrombi, deep hemorrhages and hard exudates were numerous and retinal atherosclerosis was marked. In the left eye the vision was reduced to hand movements and a horseshoe detachment below the disc was present with neo-vascularization and heaped up scar tissue. There were several scattered large pre-retinal hemorrhages.

Laboratory findings were: Urine-albumin 4 plus; sugar 2 plus; acetone 0; coarse casts; many red blood cells; blood -sugar 136; total protein 5.4; albumin 3.6; globulin 1.7; cholesterol 400; blood acetone 0. Capillary fragility was increased. Blood pressure averaged 142/90.

This patient is on 30 units of globulin insulin daily. In addition he has been faithfully taking proteinol, rutin, cevitamic acid and a lipotropic factor. In spite of therapy the retinal and facial edema have failed to subside and the retinal changes have shown no improvement. The patient is continuing a sedentary occupation.

CASE THREE

A male, aged 39, a known diabetic of three years' duration complained of poor vision for several months and redness of the right eye of one day's duration for which he sought medical attention. He confessed to haphazard control. He was a moderately obese male with a puffy face. Vision in each eye was 20/40. There was a subconjunctival hemorrhage in the temporal sector of the right bulb. The retinas showed edema and marked atherosclerosis; the veins were hugely dilated, in places sausage-like with visible pulsation transmitted to the nerve fiber layer. Hard yellow exudates were numerous. Beading, new vessels and glomerular-like tufts of capillaries with adjacent hemorrhages dominated either paramacular area.

Laboratory findings were as follows: Urine-albumin 4 plus; sugar 0; acetone 0; few hyalin and granular casts. Blood-sugar 130; urea nitrogen 15; total protein 5.2; albumin 2.6; globulin 2.6; cholesterol 300 milligrams; capillary fragility was increased markedly. Blood pressure was 136/82.

COMMENT

Of 135 fatal childhood cases of diabetes, Joslin and Wilson[8] reported that over 50 per cent of the deaths were due to Kimmelstiel-Wilson's disease.[4] This emphasizes the increasingly high incidence of this condition in the juvenile diabetic. It occurs equally in both sexes and is more frequent in young adult life after 10 or more years of diabetes. There is a constant and inflexible relationship to arteriosclerosis. The clinical picture is constant and typical. There are edema of nephrotic origin, albuminuria, hypoproteinemia, and retinopathy. The edema involves the upper eyelids and may be prominent in the retina. As the disease progresses, renal insufficiency and nitrogen retention ensue with the patient usually dying in uremia. Acidosis is rarely present. The disease may be intermittent, with death in a matter of months.

The three cases reported here all manifested the characteristic clinical picture. They differ from those originally reported in that they occurred in young persons with atherosclerosis but not necessarily hypertension. They underline the observations of Root, Story and Cortesi[9] that the lesions are actually more frequent in young persons who have had diabetes of 10 or more years.

In each instance edema of the upper eyelids was present. In the first patient, edema of the retina was very marked. This has been mentioned as part of the clinical picture but its presence in the retina has not been emphasized. The widespread edema with consequent electrolyte disturbance and hyalinization of retina and capillaries is secondary to the hypoproteinemia. There was no correlation between the degree of albuminuria and the severity of the Kimmelstiel-Wilson's disease.[4] The lowering of the blood albumin was a more reliable index to the severity of the disease and more closely paralled the retinopathy.

Premature atherosclerosis is the most common finding in young adults who have had diabetes since childhood. In the three cases presented the atherosclerosis was not accompanied by an elevation of the blood pressure. In each instance, venous distention and "micro-aneur-

8. Joslin, E. P., and Wilson, J. L.: Lessons for Future Treatment from 472 Fatalities in Diabetic Children. Brit. Med. J., 2:1293 (December 1950).

9. Root, H. F., Story, R. D., and Cortesi, J. B.: Diabetic Coma Versus Diabetic Nephropathy. The New England J. of Med., 245:765 (November 1951).

ysms" were demonstrated. The saccular phlebosclerosis was accompanied by retinal hemorrhages, superficial and deep.

Sludging of blood was noted in the retinal veins of Case Two and preceded the development of micro-aneurysms. It is possible that thrombosis takes place as a result of sludging, cell clumps adhering to the endothelium and producing coagulation. This may be responsible for the high incidence of thrombosis and hemorrhage in diabetes and be a factor in the production of the beading. Edema follows sludging due to the ensuing poor oxygenation of the tissues. Sludged blood cells are phagocytosed with ease by the reticulo-endothelial cells of the intima, a fact which may be important in the development of protein depletion. This interpretation is projected and lends support to the concept that venous stasis is an essential factor in the development of diabetic retinopathy.

None of my patients showed a significant rise in cholesterol. An elevated cholesterol may be due to dehydration and hemoconcentration and it disappears when glycosuria is controlled even though hyperglycemia persists. Long term studies are necessary to determine the role of cholesterol and the giant molecules of Gofman in the development of atherosclerosis.

Up to the present, emphasis is placed on control as the most important factor in preventing retinal lesions. Next in importance comes a lipotropic substance. It is doubtful that the low cholesterol diets in current use are effective in lowering serum cholesterol. The place of rutin in the treatment of diabetic retinopathy is still not conclusively established.

SUMMARY

1. The frequency of diabetic retinopathy is increasing steadily and occurring at an earlier age.

2. Retinal atherosclerosis is the most common finding in the young diabetic with diabetes of 10 or more years.

3. Atherosclerosis, changes in the venous capillaries, excess deposition of fat and hypoproteinemia with metabolic consequences of edema and hyalin deposition are probable causative factors in diabetic retinopathy. To this array may be added blood sludging in the retinal veins, noted in one case in this report.

4. Emphasis is directed to retinal edema and edema of the upper eyelids in Kimmelstiel-Wilson's disease.[4]

5. No patient showed a significant rise in the blood cholesterol. The role of the cholesterol metabolism must await the result of long term studies.

6. Up to the present the prophylaxis of rigid control and the use of lipotropic substances offer the best prognosis.

121 Market Street

EPILEPSY SEMINAR

The New Jersey Neuropsychiatric Association and the New Jersey Society of Crippled Children and Adults are sponsoring a program on epilepsy to be held at the Newark Academy of Medicine on October 15, 1952.

3:00 p.m.—Panel of authorities on rehabilitation of the epileptic. Moderated by Harry Sands, Ph.D.

7:00 p.m.—A group of epileptic patients will discuss how they have solved their problems.

7:45 p.m.—Demonstration of electro-encephalography and typical records.

8:30 p.m.—Film, "Seizure" produced by the Veterans Administration. This shows an epileptic veteran at home and in the hospital, illustrates the social problems and summarizes diagnosis and treatment.

9:30 p.m.—Short talks on: What is being done for the epileptic in New Jersey—Facilities for treatment—The value of the EEG—New drug and electric therapies—What can be done about prejudice?

The entire meeting is open to the medical profession and allied professions. The evening meeting should be of special interest to doctors.

DICED HOMOLOGOUS CARTILAGE IN HERNIOPLASTY *

George F. Simms, M.D., and Robert C. Irwin, M.D., Lyndhurst, N. J.

In all direct inguinal hernias, in all recurrent inguinal and femoral hernias and in all hernioplasties in patients over 45 years of age, diced cadaveric cartilage may be used to produce a buttress layer posterior to the transversalis fascia. A viable cartilaginous mosaic is grafted into the properitoneal space of the inguinofemoral region, producing an impenetrable barrier that fortifies many of the mechanicophysiologic laws of hernioplasty in the group of cases in which otherwise the failure rate is high.

Homologous cadaveric costal cartilage is obtained from autopsy material from traumatic fatalities or from people who have succumbed to degenerative diseases regardless of their age. It is not necessary to collect the cartilage under aseptic conditions. The adherent muscle tissue is removed, and the cartilage is stored, either in 95 per cent ethyl alcohol, or in tincture of merthiolate. Cartilage stored in alcohol is of firmer texture while that preserved in merthiolate is more "rubbery"; but this difference in consistency does not matter. The preserved cartilage is stored in the regular refrigerator compartment, and it is not necessary to change the preserving fluid. The supply we now use is almost two years old. It has never been cultured.

The perichondrium is not essential; no attention is paid to its presence or absence. At operation, pieces of cartilage are removed from the preserving fluid under aseptic conditions. It is diced by the surgical assistant into variable sized pieces approximately one centimeter square by 2 to 3 millimeters in thickness. Larger or smaller pieces may be used. These pieces are considerably larger than those used by the plastic surgeon.

The standard hernioplasty procedure is followed until after the conjoined tendon and transversalis fascia in Hesselbach's triangle are sutured to either the inguinal ligament or Cooper's ligament depending upon the technic being followed. The diced cartilage is then packed posterior to the sutured transversalis fascia and anterior to the peritoneum. This is done prior to any suturing lateral to the region of the internal inguinal ring. The repair then proceeds lateral to the internal ring and cord or round ligament, suturing the internal oblique and the transversalis fascia to the inguinal ligament. Diced cartilage is then packed under the transversalis fascia lateral to the internal ring. Two or more pieces are also placed directly caudad to the internal ring. These are very important. No attempt is made to retain the cartilage in place with sutures. The total amount of cartilage used in each repair is equivalent to a piece of cartilage 1½ to 2 inches in length. The hernioplasty is then completed as in the Willys Andrews' technic. Chromic sutures are used throughout.

Cadaveric cartilage *in situ* does not grow unless it was obtained from a child. Yet it lives, as can be seen on histologic sections. Its viability conforms to the process which Nageotte termed "reviviscence". The diced cartilage is encapsulated in fibrous tissue and makes a fixed total mass. The fibrous capsule contains blood vessels. A single small piece of diced cartilage implanted under the skin shows a range of motion of about a half centimeter. To obtain a fairly compact total mass, it is necessary to pack the cartilage closely since union between pieces is obtained through its ensheathing fibrous capsule developed after it is placed *in situ*. There is no cartilaginous union between the diced pieces.

Cartilage grafts should not be compared to living homologous fascial grafts. In our experience with fascial grafts (both strips and full sized pieces) the results in hernioplasty were no better than if a routine repair was done. The difference may be explained on a histologic basis. The fascial grafts are united to the host by an ingrowth of fibroblasts into the fascia and a gradual replacement of the fascia by connective tissue. The latter tissue is not

* From the Presbyterian Hospital, Newark, N. J.

supportive enough to withstand increasing pressure. Cartilage is not replaced by connective tissue. It remains as such in the host as an additional firm but pliant supporting layer.

Diced cartilage in hernioplasty has now been used by us over a five year period without any bad effects. We have had no infections, no pain, no increase in post-operative morbidity, no complications and no recurrences. It offers a distinct improvement. It will decrease, if not totally eliminate the incidence of recurrent hernias.

541 Page Avenue

STREPTOKINASE AND STREPTODORNASE IN ABDOMINOPERINEAL RESECTIONS

Since the operation was first introduced, surgeons have been faced with management of the posterior wound after extensive abdominoperineal resection for malignancies of the rectum. The problems associated with this operation include adequate posterior resection to insure removal of the entire malignant tumor, control of bleeding in the cavity of the sacral hollow, and the prevention of infection. Previously, a large dead space was left behind in the pelvic cavity after radical dissection for rectal carcinoma. This dead space has been controlled by extensive packing and drainage. The disadvantages of this method are a prolonged healing time of from three to six months or longer, constant care and frequent dressings, and discomfort and restricted activity of the patient. Recently, partial or complete closure of the posterior wound has been recommended to overcome some of these disadvantages. The main problem in primary closure is obliteration of the dead space.

If no pack is used, normal intra-abdominal pressure pushes the peritoneal floor into the pelvis, and if this space is kept free of serum and blood, it may be obliterated by the development of peritoneal-pelvic adhesions. The use of streptokinase and streptodornase to accomplish this has recently been advocated.[1] Streptokinase effectively liquefies blood clots, and streptodornase does the same to purulent exudate. In performing primary closure in abdominoperineal resections, the posterior wound is closed, leaving two or three Penrose drains and a size 14F urethral catheter in the hollow of the sacrum. Postoperatively the patient is given dihydrostreptomycin 0.5 Gram four times a day, plus procaine penicillin, 600,000 units daily. Seventy-two hours postoperatively the urethral catheter is irrigated with 100,000 units of streptokinase and 20,000 units of streptodornase, in a total volume of 20.0 cubic centimeters. The patient lies supine for four to six hours to permit puddling of the solution in the hollow of the sacrum. There is normally a large amount of drainage, representing dissolved clots and necrotic tissue. This procedure is done every other day for four to six times, after which the drains and catheter are removed. The results have been very encouraging in the hands of these surgeons and merits the attention of others doing this type of extensive pelvic resection.

1. Beahrs, O. H., and Jordan, G. L., Jr.: Use of Streptokinase and Streptodornase in the Primary Closure of the Posterior Wounds Following Combined Abdominoperineal Resections for Malignant Lesions of the Rectum and Lower Part of the Colon. Proceedings of the Staff Meetings of the Mayo Clinic, 27:241, June 18, 1952.

UROLOGY AWARD

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of clinical or laboratory research in urology. Competition is limited to urologists who have been in specific practice for not more than five years and to doctors in training to become urologists.

For full particulars write to Mr. William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 15, 1953.

STATE ACTIVITIES

A SPECIAL REQUEST

The Trustees of Medical-Surgical Plan of New Jersey have requested the editor to call the particular attention of members of the Society to the text of the Supplemental Report presented by the Plan to the House of Delegates of the Society at its last Annual Meeting in May 1952. This Supplemental Report, together with the regular Annual Report of the Plan, was unanimously approved by the House of Delegates.

Text of the *Supplemental* Report begins on page 26 of the TRANSACTIONS of the Annual Meeting. The text of the regular Annual Report of the Plan was published in the May 1952 issue of the JOURNAL.

Both reports (particularly the Supplemental Report) contain important factual information concerning recent developments of the Plan which are of immediate and practical interest to every physician.

The attention of our readers is also directed to the informative address presented to the House of Delegates in connection with the Tenth Anniversary observance of Medical-Surgical Plan, the texts of which appear in the TRANSACTIONS.

BETTER BREAKFAST WEEK

The Medical Society of New Jersey is sponsoring "Better Breakfast Week" during the seven day period beginning October 19, 1952. Displays, exhibits and pamphlets are now available for *your office*. Obtain your displays and supply of literature today. You may get it from the office of your county medical society or from the chairman of the "Better Breakfast Week" committee, Dr. S. W. Kalb at 416 Clinton Place, Newark.

Recent surveys spotlight the need for better breakfasts in almost all occupational and age groups. One child in five goes to school with an inadequate breakfast under his belt. Workers who skip breakfast—or skimp on it—get less done in the first morning hours than their smarter colleagues. Most teen age girls eat inadequate breakfasts.

AMERICAN TRUDEAU SOCIETY

The annual meeting of the Eastern Section of the American Trudeau Society will be held Friday and Saturday, October 31 and November 1, in Philadelphia. Headquarters will be the Bellevue-Stratford Hotel. Members of the Society wanting to present papers are urged to communicate promptly with the Chairman of the Program Committee, Dr. Katharine R. Boucot, 311 Juniper Street, Philadelphia, Pa.

FELLOWSHIP FOR ARTHRITIS RESEARCH

The Arthritis and Rheumatism Foundation offers research fellowships in basic sciences related to arthritis. The grant ranges from $1500 to $6000 a year, depending upon the training level of the Fellow. Deadline for application is November 1, 1952. For information write to the Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, New York.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, May 9, 1952, DR. ANTHONY G. MERENDINO, presiding.

Dr. Weintrob reported on the activities of the Broadcasting Committee for the past year, stating that about fifty broadcasts had been given over two radio stations. Dr. Weintrob further reported on the plans that his committee had made for the annual outing.

Dr. Holland, reporting for the Public Relations Committee, stated that the E.M.S. Plan was now functioning smoothly and that specific information as regards its operation would be listed in the new telephone directory. It was moved by Dr. Holland that a committee be appointed to study the feasibility of obtaining a house to serve as a future home for the Society. The motion was seconded and carried, and the appointment was referred to the incoming President.

The Treasurer submitted his annual report, noting an increase of over 200 per cent in the income derived from the *Bulletin* due to the efforts of Drs. Diskan and Mishler.

Dr. Walter Stewart, reporting for the Library Committee, stated that the Hospital library had been kept up to date with new books and periodicals, and he moved an appropriation of $300 for the maintenance of the library for the coming year. Motion was carried.

Dr. Clifford Murray, in his report for the Red Cross Blood Procurement Committee, stated that the program is receiving poor support and that the procurement of blood in this county is far below the reasonable goal that had been set. He urged all members to take a more active part in stimulating interest in this vital necessity.

Dr. Robison Harley announced for the Conservation of Vision Committee, that eighteen talks had been given before various county P.T.A. groups.

Dr. Eugene Dalton brought to the Society's attention a program, devised by his committee, for the screening of all school children for the detection of hearing defects. Dr. Dalton also reported on a proposed plan for the screening of all applicants for drivers' licenses in New Jersey for the purpose of detecting hearing defects. This work is being done in conjunction with the N. J. State Motor Vehicle Department and various otological societies.

Dr. Molitch reported for the Pharmacists' Liaison Committee and announced that a new set of rules regulating the writing of prescriptions had been formulated.

Dr. Diskan submitted a report on the successful operation of the Bulletin this year, stating that the publication was now on sound financial footing. He also suggested that recognition of the achievements of past and present Society Presidents be shown by the Society in the form of certificates of honor and a suitable symbolic emblem, and he accordingly made a motion to that effect. Dr. Allman proposed that the Bulletin Committee supervise this program, and the motion and its amendment were seconded and carried.

The following were elected: President—DR. ROBISON D. HARLEY, Vice President—DR. E. HARRISON NICKMAN, Secretary—DR. LOUIS ROSENBERG, Treasurer—DR. JOHN W. HOLLAND, Reporter—DR. LEONARD B. ERBER, Historian—DR. WALTER B. STEWART.

Dr. Harley spoke briefly of his plans for the coming year.

A motion was made by Dr. Holland, duly seconded and carried, that the dues for the coming year be fixed at $35.00.

VOLUNTEER ARMY

A citizen army two million strong goes into action in October to insure the nation's health and welfare for the year to come.

Vounteers in a united campaign to raise money for some 17,000 Red Feather services, these men and women will solicit their fellow citizens for contributions to home town agencies and national health and welfare programs such as those made necessary by the defense effort.

This once-a-year campaign by the country's Community Chests and the United Defense Fund insures the health and welfare services so vital to the entire community.

Volunteer *your* time now to your town's united Red Feather Campaign.

THE NEW JERSEY ALLERGY SOCIETY

Frank H. Feldman, M.D., Chairman of Publicity

At the last meeting of the *New Jersey Allergy Society* the following officers were elected: President—DR. WILLIAM GREIFINGER, Newark; Vice-President—DR. EDWIN SEIDMON, Plainfield; Secretary—DR. WILLIAM NEVIUS, East Orange; Treasurer—DR. JOSEPH SKWIRSKY, Newark.

On October 16, 1952, the New Jersey Allergy Society is having a meeting combined with the stated meeting of the Academy of Medicine of Northern New Jersey. Dr. Leo H. Criep, Assistant Professor of Medicine of Pittsburgh School of Medicine, will speak on the management of the allergic child.

BOOK REVIEW

Fluid Balance—A Clinical Manual. By Carl A. Moyer, M.D. 1952. Year Book Publishers, Chicago. Pp. 191. ($3.75)

Ever since Claude Bernard introduced the concept of *milieu interieure,* biochemists have been investigating the role of fluid and electrolytes in human physiology. A mass of literature has accumulated which becomes more confusing each day. Yet an understanding of fluid balance in the management of seriously ill patients, whether medical or surgical, is imperative. Moyer, in this small manual has done an outstanding piece of work in simplifying this complex field.

After a brief historical review, the chemistry of the normal body fluids is described in sufficient detail to be comprehensible without being obscure. Emphasis is placed on the normal metabolism of the various electrolytes, and on clinical methods of determining their derangement. Simple tests are described and the signs of electrolyte abnormalities are clearly presented. Acidosis and alkalosis are discussed, and fluid abnormalities in surgical patients explained. A section is devoted to fluid therapy and its complications.

This book is primarily designed to acquaint surgeons with the problems of fluid balance, and to instruct them in the management of such problems. The book is compact (pocket size) and will serve as an excellent introduction to this confusing and difficult topic. It is recommended to all who wish to learn the rudiments of fluid balance, and to those students for whom this has always been a baffling branch of medical science.

R. D. Goodman, 2d, M.D.

The Clinical Use of Fluid and Electrolyte. By John H. Bland, M.D. Pp. 259. Philadelphia, W. B. Saunders Co., 1952 ($6.50)

This book represents the second of a series published in a paper binding using a rough, dull paper. The type resembles typewriter style and represents offset printing. This makes it possible to bring the material cheaply to the practitioner. This is desirable since the material is new in content and rapidly changing in its facts. However, it is difficult to read. Each line is 7 inches long and the eye becomes tired as it sweeps across the pages. Illustrations are all line drawings. No photographs can be used with this type of paper. This has disadvantages in reproducing electrocardiograms. There is no cross index of the material in the monograph. This makes the book difficult to use with any economy of time.

The subject matter itself is extraordinarily good. The author has covered each of the fields in which electrolytes are of importance. Though of necessity there is not a complete assessment of all the facts on each chapter, certainly the author has done as well as one could expect with the rapidly changing ideas in the field in which he is dealing. The disadvantage of this type of publication is best demonstrated in the chapter on "Normal and Abnormal Potassium Metabolism" where electrocardiographic changes associated with potassium levels are illustrated by line drawings. Though these are probably tracings of actual electrocardiograms, it certainly gives a peculiar picture and would be difficult for the uninitiated to translate into the actual electrocardiograms.

In summary, then, we have an attempt to bring to the practitioner at a low cost new material on an important subject by a new method. In this particular monograph, we have a very fine presentation of the material, but its value is somewhat diminished by the method of presentation.

Arthur Bernstein, M.D.

Dynamic Psychiatry: Transvestism. By Louis S. London, M.D. Pp. 129. New York 16, N. Y. 1952. Corinthian Publications. ($2.50)

Building a book around a single case is an obsolescent technic of medical writing, though it has some advantages. In volume 2 of his *Dynamic Psychiatry* series,* London reports a case of transvestism complicated by a morbid desire for deformed women. The book is curiously out of proportion. Seven pages are devoted to a discussion of transvestism in general, five pages to reprint of an old case reported by Hirschfeld, 14 pages to an analysis of the case here presented, and the rest of the volume (103 pages) to fantasy drawings of crippled women made by the patient together with the patient's own brief footnote to each drawing. As in London's other books, his basic weakness is his failure to spell out his treatment technic, so that his material is always more interesting than useful. There is practically no exposition of how the psychiatrist treated this patient, though the book closes with the remark that the patient's oedipus complex has at last been resolved.

William Schram, M.D.

Sex and the Law. By Judge Morris Ploscowe, Prentice-Hall, New York, 1952. Pp. 310. ($3.95)

Any book with "Sex" in the title is likely to become a best seller; and is likely to turn out to be sensational rather than sound. This book, however, is a sober, serious study of the state of the law with respect to marriage, annulment, rape, prostitution, sodomy and illegitimacy. The Judge writes in a lucid and interesting manner and reveals all sorts of vagaries in the law which will be informative (and sometimes amusing) to the reader. He is not content with reciting legal absurdities, however. He proposes specific reforms in each chapter.

For example, fraud is a basis for annulling a marriage. Suppose a girl falsely tells her boy friend that, as a result of his attentions, she has become pregnant. He marries her only to find that, in fact, she does not have and never did have any ovaries. The marriage cannot be annuled on the grounds of fraud. Apparently telling him she was pregnant was a sort of finesse with the queen of hearts. It wasn't a fraud. Nor can the marriage be annuled on the grounds of lack of capacity

* The first book in this series, *Basic Principles,* was reviewed on page 122 of our March (1952) Journal.

either. The law says that since she can still submit to intercourse, she stays married. Apparently that is all there is to marriage according to the court (presumably composed of bachelors) which wrote *that* decision.

The laws with regard to sexual perversions are completely baffling. The law is either too vague or too delicate to define sodomy, for instance. One state does list a number of acts which meet that definition, one of which is carnal knowledge of a bird by a woman. The generosity with which the law defines statutory rape is frightening. We also learn that if a wife remains a virgin for three years, the husband is presumed to be impotent, and if he says that he failed to have intercourse simply because his wife did not want him to, "he deserves to be doubted" (and I quote) "for not having asserted his rights even though she balked". The Judge gives the "sex psychopath" laws a going over and he doesn't like any of them. He reviews the Mann Act and cites some astonishing examples of convictions under that statute. This law was designed only to prevent compulsory prostitution but is so worded ("transportation for immoral purposes") as to embrace much else. Jerseyites will possibly be indignant about the sad case of the Newark resident who, while wintering in Florida, sent his girl friend enough money to come south and join him. He was convicted of violating the Mann Act as well as of having perpetrated it.

The illegitimacy laws are completely bewildering. In Nebraska if the parents of a bastard marry each other, the child becomes legitimate only after this marriage has produced a second child. Until that happens he is, apparently, only a conditional bastard. If Nebraska has conditional bastards, New York has semi-bastards. In the Empire State, a marriage can be annuled if it turns out that one of the partners was mentally imcompetent. The child then remains legitimate with respect to the sane parent, but is illegitimate with respect to the incompetent parent. Semi-bastardy thus becomes a recognized legal status. Come to think of it, I know a few people who probably fit into that category.

VICTOR HUBERMAN, M.D.

Medical Biographies. By Philip Marshall Dale, M.D. University of Oklahoma Press, Norman, Oklahoma, 1952. Pp. 259. No. index. ($4.00)

Napoleon did not die of cancer of the stomach—even though that is what the autopsy showed. He had ulcers. Variations in the healing of his ulcers and in his secondary anemia accounted for fluctuations in Napoleon's skill, thus markedly affecting the entire political and military history of Europe. That's what Dr. Dale says in this book—an analysis of the medical biographies of 33 famous persons. The material is intrinsically dull, but Dr. Dale has a waspish sense of humor and a feel for whimsy which converts this inherently unexciting material into interesting reading. That Columbus died of heart disease and Willam the Conquerer of the effects of an abdominal injury would, ordinarily, make one say "So what?". However, Dr. Dale does manage to crowd his pages with anecdotes of medical interest so that the reader is absorbed, and turns eagerly to the next chapter in the hope that this time something really interesting will be presented.

Underlying the book is the implication that, in many of these persons, ilines played a role in the shaping of history. To demonstrate this, Dr. Dale has to strain a bit. Thus, Phillip II suffered from arthritis, and this says the author "was of historical importance because it largely explains the unspeakable cruelties inflicted upon victims of the Spanish Inquisition". It is doubtful if many critical historians would accept this explanation for the Inquisition. The book lists 1682 as the birth year for Peter the Great and says he became a father in 1690 which is going some, even for a Russian. The volume is intended, presumably for laymen, and it is unfortunate that he includes such easily misinterpreted statements as "it is doubtful if the victim of manic-depressive attacks is ever quite normal-minded at any time in his life"; and "Miscarriages are the spoor of syphilis". And my nomination for the "Go climb a tree" department is Dr. Dale's remark that "Dr. Dick, though born and trained in America, had a brilliant mind".

HENRY A. DAVIDSON, M.D.

Psychiatry and Medical Education. John C. Whitehorn, M.D., Editor. Washington, D. C., 1952. American Psychiatric Assn. Pp. 164.

In June 1951, under the joint sponsorship of the Association of American Medical Colleges and the American Psychiatric Association, with a financial grant from the Public Health Service a group of educators and psychiatrists sat down to exchange ideas on the status of psychiatry in undergraduate medical education. This book is an edited and integrated account of that conference. It is not a collection of speeches like strings on a bead. It is rather, a fusion of the thinking. It comes up with no neat recommendations. What it does is review in literate and readable fashion many facets of the problem: the selection of medical students, the content of the psychiatric "course" in medical schools, the technics of presentation, the role of the community, the utilization of state hospital resources, the relative importance of focussing on the psychoses, on the psychoneuroses or on psychosomatic problems and the method of integrating psychiatry with all medical teaching. It is a thought-provoking source book for any one interested in the subject. It asks more questions than it answers.

ABRAHAM LEFF, M.D.

Elementary Medical Statistics: Principles of Quantitative Medicine. By Donald Mainland, M.B. Pp. 327. Philadelphia, 1952. Saunders. ($5.00)

Many medical practitioners shy away from a book on statistics. They consider it both complicated and irrelevant. In truth, however, the ability to handle statistical concepts is essential not only to the researcher and the epidemiologist but also to any practitioner who wants to understand them. In a short but interesting opening chapter, Mainland discusses the place of statistical treatment in medicine in a manner that corrects some misconceptions and alerts the reader's interest. Lucidly and logically he demonstrates the

fundamental concepts of statistics which, when understood, aids the student, the practitioner and the investigator in evaluating what they read in journals, provide standards by means of which clinical impressions can be evaluated, and give mastery of some simple statistical technics. Thus, "probability judgments" are continually being made in medicine. It is difficult to think of anything in diagnosis or research which does not depend on measurement or counting, directly or indirectly, and the interpretation of the significance of such data.

Problems of evidence, bias, and sampling are examined. The discussions cover the assessment of and tests for significance in statistics, the frequency distribution, probability, the effects of chance in sampling, variation between measurements, the interpretation of graphs, correlation and other statistical principles and methods.

Examples used to illustrate points under discussion are taken predominantly from investigative and clinical literature. Several chapters end with cerebral-bestirring questions, the answers to which are given elsewhere in the book.

The reviewer has already recommended this timely book to a number of practitioner friends since knowledge of the material contained therein would illuminate and make much more meaningful many of the things we daily read about, think about and act upon.

B. P. Sonnenblick, Ph.D.

A Textbook of Pharmacology. By William T. Salter, M.D. Pp. 1240. Philadelphia, W. B. Saunders Company, 1952. ($15.00)

Pharmacology is the youngest of the basic medical sciences. Very few books are available dealing with this important field. The publication of their new textbook, written by Dr. Salter, is most welcome. The author, professor of pharmacology at Yale University, is a well-known authority on the subject. The book opens with a brief history of the subject and presents the elementary principles of prescription writing as well as those of the administration and action of drugs. Next follows a section on drug action on physiologic mechanisms. Part 3 carries the title "Application of drugs in clinical medicine", and treats the subject in reference to the various body systems. It devotes ample space to the chemotherapeutic and chemoprophylactic agents. Also included is a condensed revue of elementary clinical toxicology.

The presentation of the entire subject is excellent, the scope is broad, the style concise, the diction simple. Each chapter contains brief descriptions of the properties, chemistry, pharmacodynamics, action on special systems, possible toxic effects, absorption, metabolism, fate, clinical application, available preparations, variants and standardization of the pharmaca in question. At the end of each chapter there is a special paragraph devoted to "unsolved problems" and also a brief synopsis followed by references. The discussions of the unsolved problems add immeasurably to the attractiveness of the treatise, rounding out the subjects. They will help to challenge and promote the research of the future.

Dr. Salter calls his book "a personal book" of a man who has spent many hours at the bedside, in the laboratory and in the lecture room. The text reflects his thorough knowledge of the subject and his great experience and skill as its teacher. He wrote it chiefly for the medical student and practitioner, but doctors in all branches of medicine, looking for valuable information in pharmacology, will find it most useful and stimulating as a reference compendium.

William Nyiri, M.D.

Between Two Worlds: The Memoirs of a Physician. By Benjamin L. Gordon, M.D. New York, 1952. Bookman Associates (Twayne Publishers) Pp. 354. ($4.00)

Recently honored by the Atlantic County (N.J.) Medical Society, Dr. Gordon has long been active in the three fields of medical history, the Zionist movement, and contemporary ophthalmology. In this absorbing and, at times moving, autobiography, he paints a picture of his early days in Czarist Russia, his flight to the United States, the Jefferson Medical College in the late Victorian age, the practice of medicine at the turn of the century, and the ups and downs of a busy, socially-minded practitioner. The story is jam-packed with anecdotes funny, serious, touching, tragic, informative and interesting. Particularly significant to physician-readers is his account of how one qualified for medical school in the 1890's (a brief examination in English, history, physics and chemistry, a handshake with congratulation, "you're in" some thirty minutes later), how one studied medicine and how an unknown young doctor opened an office and attracted patients. Dr. Gordon established a splendid family which, like himself, have made substantial contributions to America. The autobiography serves to remind us that, except for the Indians in our midst, all Americans are the descendants of immigrants.

Ulysses M. Frank, M.D.

Heredity in Uterine Cancer. By Douglas P. Murphy, M.D. Pp. 128. Cambridge, Harvard Univ. Press, 1952. ($2.50)

The study deals with the occurrence of cancer among the relatives of 201 women who were suffering from cancer of the uterine cervix and of 213 control probands. The evaluation of the history and cases made it advisable to combine the figures for cancer of the cervix and cancer of the uterus and, consequently, there was no attempt to evaluate the frequency of cancer of the cervix alone. The evidence supports the conclusion that hereditary factors affect the frequency with which cancer appears in the uterus. The proportion of cases of uterine cancer to all cases of cancer was significantly higher in the cancer family groups. The study also indicates that the factors which predispose to uterine cancer do not predispose in any significant degree to cancer in other sites. Results of the investigation indicate that hereditary factors (other than those concerned with uterine cancer) play a role in cancer elsewhere in the body. Whether these factors influence the incidence of cancer in specific sites or in all sites (other than in the uterus) is unknown. In all a readable, thought-provoking and important little book.

Ben Liebner, M.D.

Volume 49
Number 9

TUBERCULOSIS

ABSTRACTS

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXV September, 1952 No. 9

LYMPH NODE TUBERCULOSIS AND ITS TREATMENT IN ACCESSIBLE NODES

By Charles W. Lester, M.D., The American Review of Tuberculosis, December, 1951.

Lymph node tuberculosis appeared in the literature in the fifth century when Clovis, King of the Franks, applied the "king's touch" for the treatment of scrofula (tuberculous cervical lymphadenitis). This form of therapy continued in vogue for more than 1,200 years until it was abandoned early in the eighteenth century after Queen Anne had used it unsuccessfully on Samuel Johnson. Thereafter, various forms of medical and surgical treatment proved equally ineffective until early in the present century, when the surgical technique was revised to produce excellent results from the cosmetic as well as the clinical aspects. In the early nineteen twenties the incidence of tuberculous infection of accessible lymph nodes (neck, axilla, and groin) declined markedly. Now, it seems to have been forgotten that lymph node tuberculosis presents its own special problems.

Lymph nodes are involved early in the course of tuberculosis, as in the primary complex of the pulmonary disease of childhood; and it is logical to assume that the origin of infection in the peripheral nodes also lies in the area drained by them. The focus cannot always be found and may have healed. All cases cannot be explained on this basis, however, and undoubtedly hematogenous infection plays an important role. The predilection for the neck in hematogenous infection is probably due to lowered tissue resistance due to previous infections of a different nature.

The human type of tubercle bacillus, rather than the bovine, is responsible for most cases of lymph node disease in spite of a widespread impression to the contrary. In 1908 more than 70 per cent of a considerable number of tuberculous nodes removed from the necks of children in New York City showed the human type of tubercle bacillus. Since that time the bovine infection in humans has practically disappeared.

Tuberculosis usually commences as a generalized infection with a systemic reaction. The local manifestations are characterized by an acute inflammatory process, the exudative phase and, when lymph nodes are involved, this is followed by tubercle formation, caseation necrosis, and cold abscess. The process may be halted by fibrosis or calcification but there is always a perilymphadenitis present which binds the involved nodes and the surrounding tissue together. Liquefaction starting within the node usually perforates slowly into the surrounding tissue, and the resulting cold abscess has a wall of fibrous and tuberculous granulation tissue. When the pathologic process is halted by fibrosis, the encapsulated caseous material and tuberculous pus harbor organisms capable of reactivating the infection for an indefinite time. Tuberculous lymphadenitis may be only the local manifestation of a general infection with active foci elsewhere, which must always be sought.

The ideal treatment for tuberculosis, regardless of its site, is surgical eradication if possible, although this course, when applied to tuberculous cervical lymph nodes, seems to be the subject of controversy. This is hard to understand. Excisional therapy for pulmonary tuberculosis is a widely accepted and efficacious form of treatment and the same principle applied to lymph node tuberculosis should be even more effective and certainly less hazardous.

The same principles apply to the selection of all cases of tuberculosis for surgery. The patient

should be a "good chronic." Operation should not be undertaken during an acute exudative infection nor attempted with active foci elsewhere in most cases. The condition of the patient should be good enough to permit a long operation.

Incisions are made in, or parallel to, natural creases for cosmetic reasons. All the diseased nodes should be removed and, as the process is always more extensive than it appears to be, this requires careful, sharp dissection. Cold abscesses with the underlying nodes are dissected out, not simply curetted and drained. Contamination of the wound with tuberculous pus will not make drainage necessary. All of the important structures are preserved except, rarely, the mandibular branch of the facial nerve which may be damaged, although often only temporarily.

In this respect the operation differs materially from the radical neck dissection for malignancy where important structures are sacrificed to ensure complete removal of malignant cells. With tuberculous nodes it is better to preserve the structures and perform another operation if necessary. In the end result the scar is inconspicious, deformity is absent, and the disease is controlled.

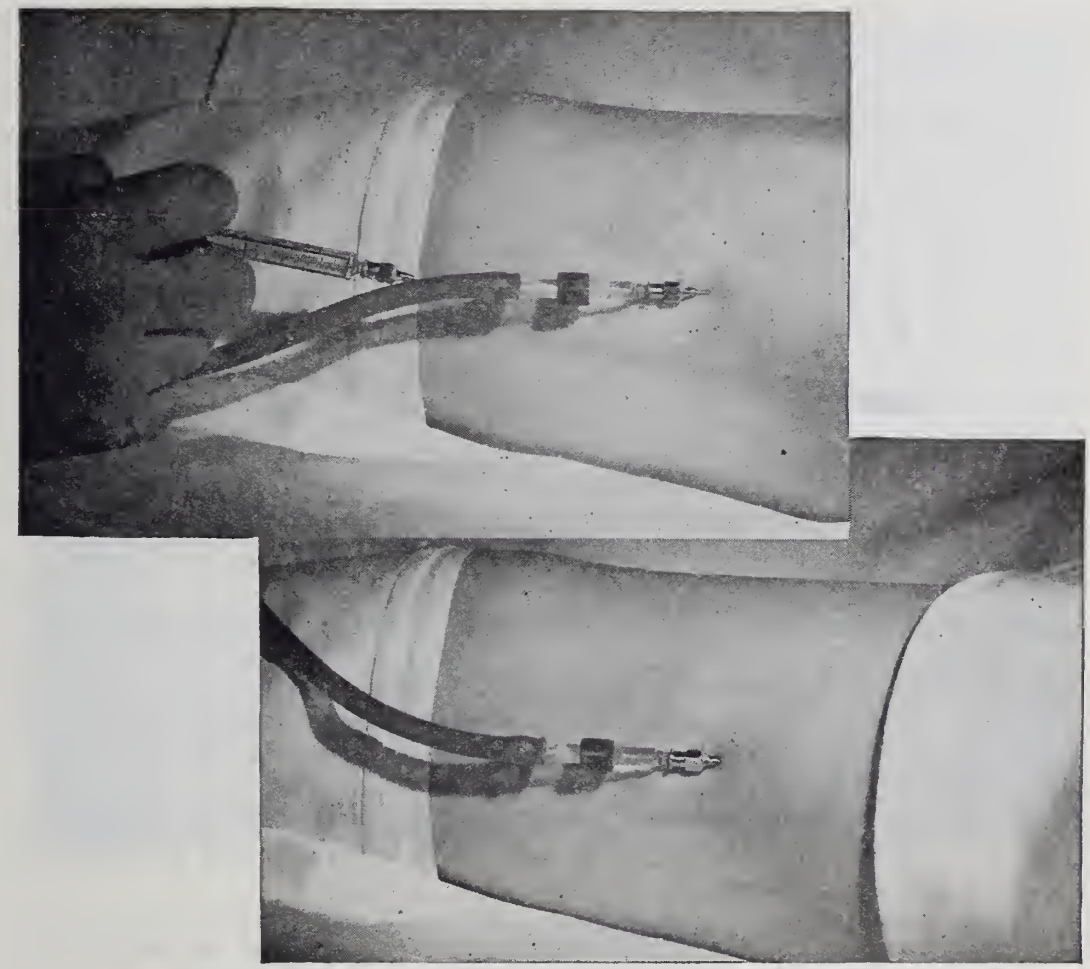
In some cases surgery is inadvisable, in others it is unnecessary, in still others it requires the help of other forms of therapy. Rest, adequate diet, and hygienic surroundings should be used in the acute form of the disease, and in the mild forms no other treatment may be needed.

In treating tuberculous nodes roentgen irradiation produces fibrosis and helps to encapsulate the disease. It cannot destroy *Mycobacterium tuberculosis;* it cannot remove caseation; it cannot cause the absorption of tuberculous pus and may hasten its appearance. Furthermore, the incidence of activation of tuberculosis in other parts of the body after irradiation of lymph nodes has often been observed. It can be a valuable adjunct in the treatment of sinuses after the caseation has largely disappeared and in that stage of the infection between the exudative phase and the establishment of caseation.

Chemotherapy, notably with streptomycin and para-aminosalicylic acid (PAS) is a recent and valuable addition to the therapy of tuberculous lymphadenitis. Antimicrobial drugs are most effective on the early, exudative form of the disease and have little value in the treatment of caseous foci or cold abscesses. However, chronic tuberculous sinuses respond well if the microorganisms are sensitive to the drug. Prolonged use of the drug will result in drug-resistant microorganisms. The concomitant use of PAS will retard this resistance. Antimicrobial drugs should be employed with discrimination lest an occasion arise later when the drug is urgently needed and proves to be ineffectual. The most recent adjunct to therapy is the streptokinase-streptodornase combination of proteolytic enzymes. Peripheral lymph nodes may become involved in the course of pulmonary tuberculosis and they are prone to break down into cold abscesses. Because of the pulmonary focus, excision of the nodes is inadvisable and simple drainage results in chronic draining sinuses. However the use of these enzymes in the cold abscess cavity after wide drainage has been established produces a biologic debridement of the caseous material, permitting the growth of healthy granulations and closure of the sinus.

Tuberculosis in peripheral lymph nodes, particularly the neck, is still frequently encountered by the physician. These infected nodes lend themselves to surgical excision. When operation is inadvisable or unnecessary, other forms of treatment are available which can also be used as an adjunct to surgery. Good results can be expected if the limitations as well as the potentialities of the various forms of therapy are heeded.

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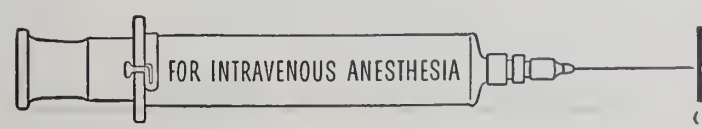


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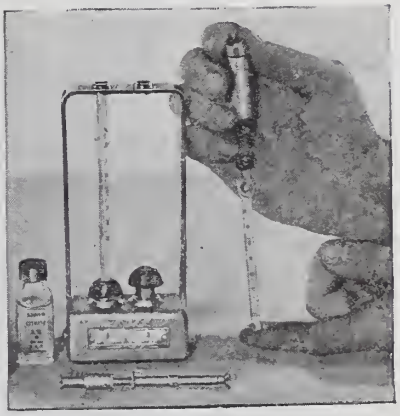
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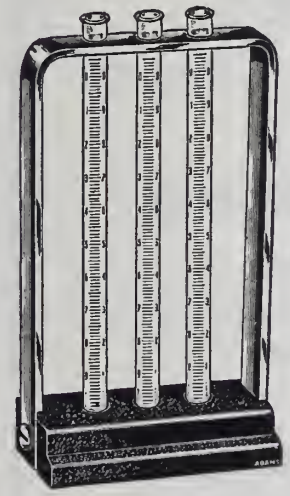
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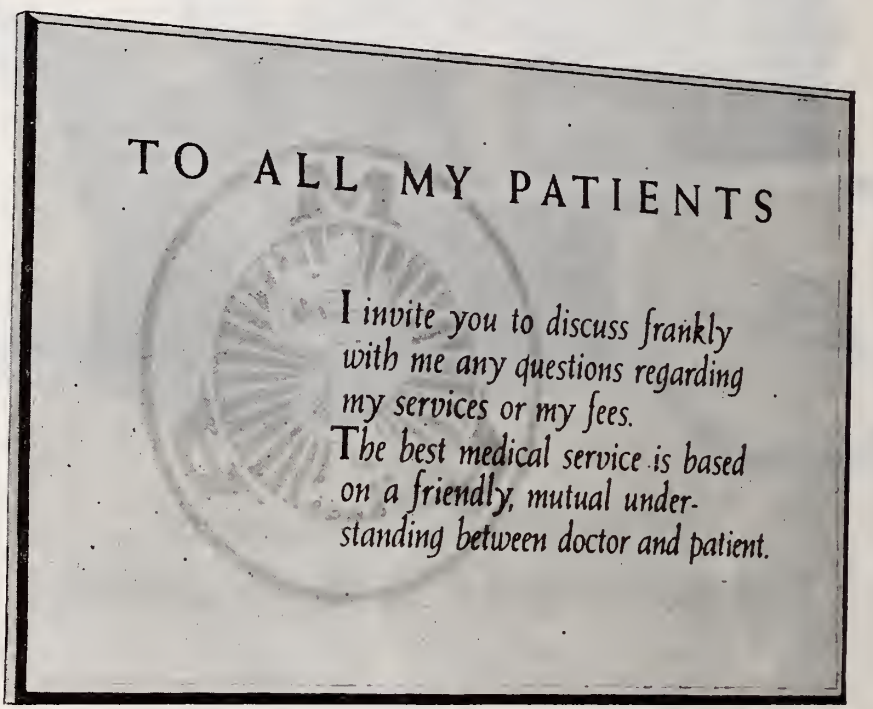
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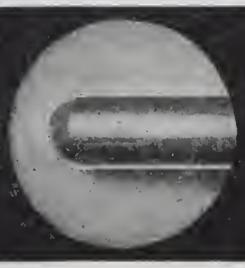
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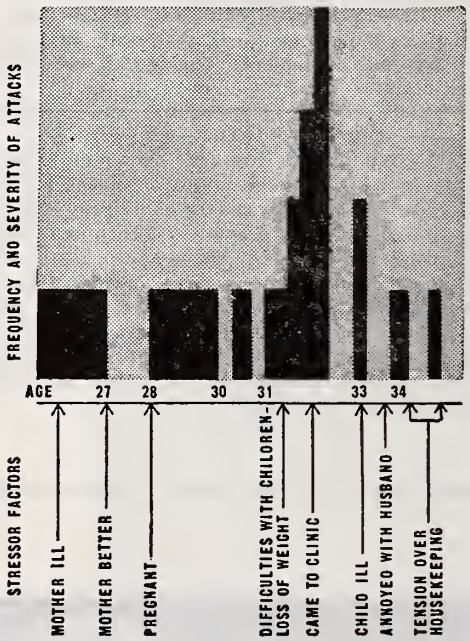


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[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

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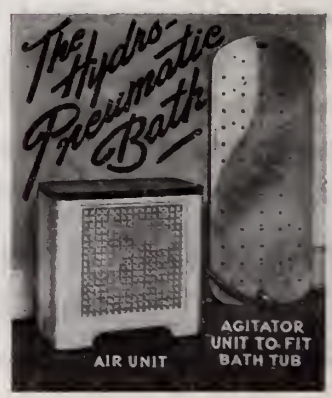
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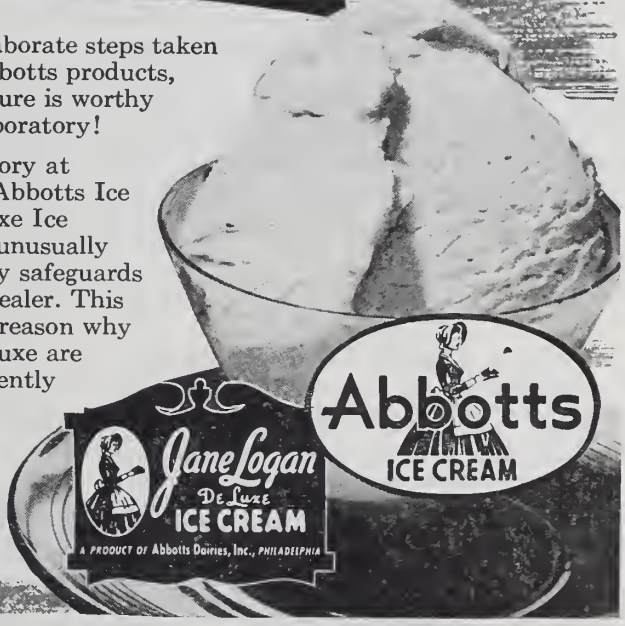
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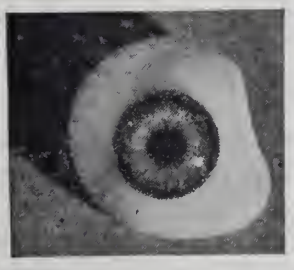
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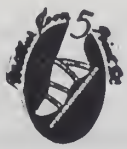
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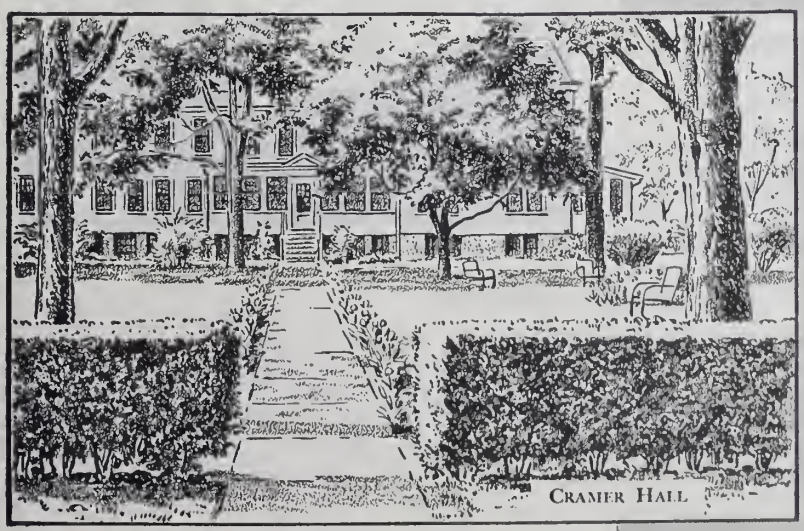
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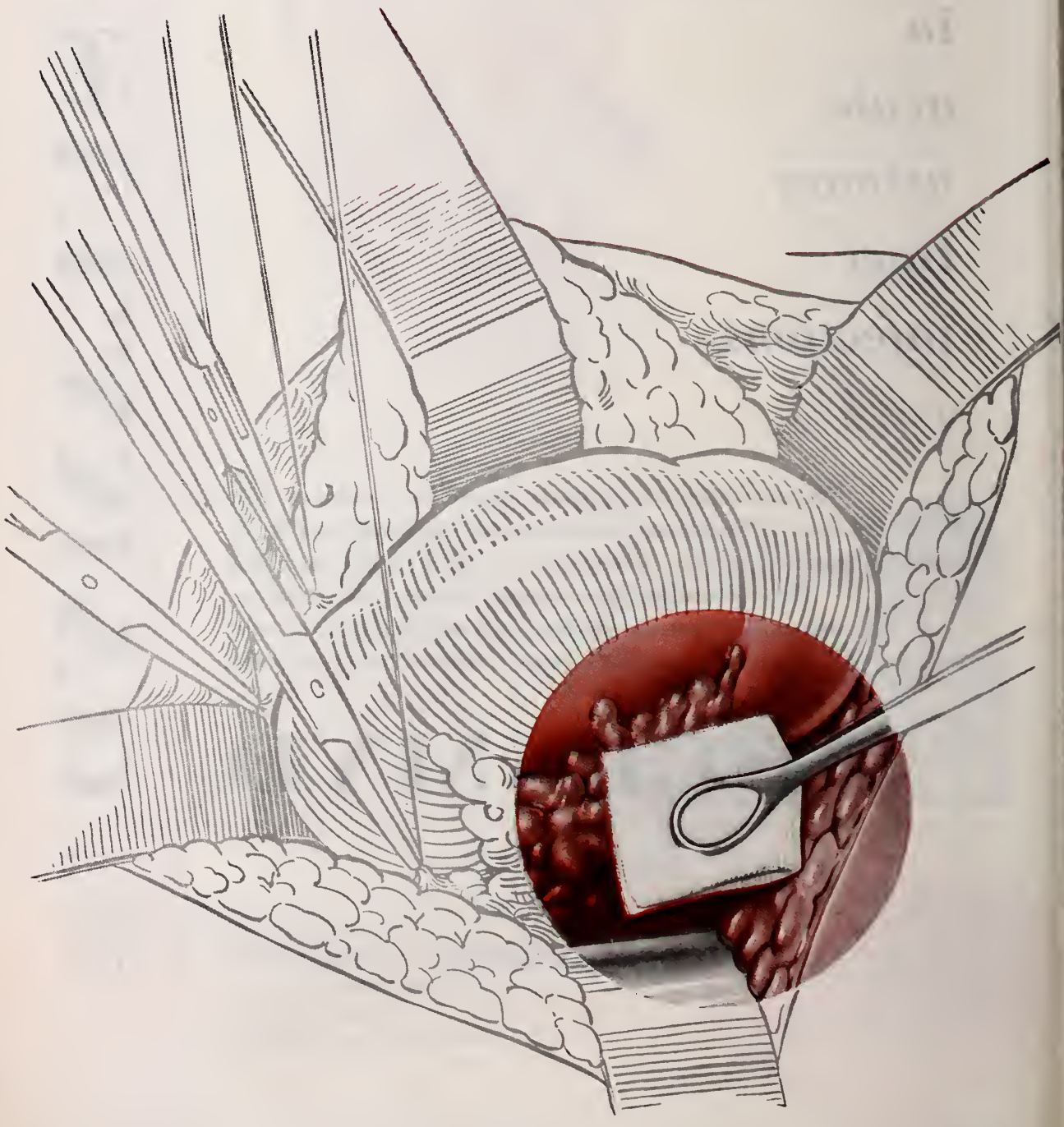


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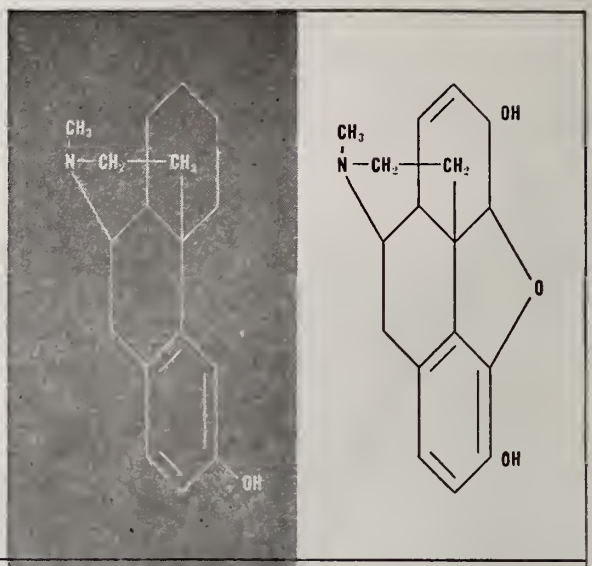
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THE CLINICIANS

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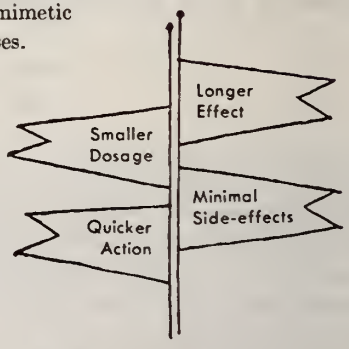


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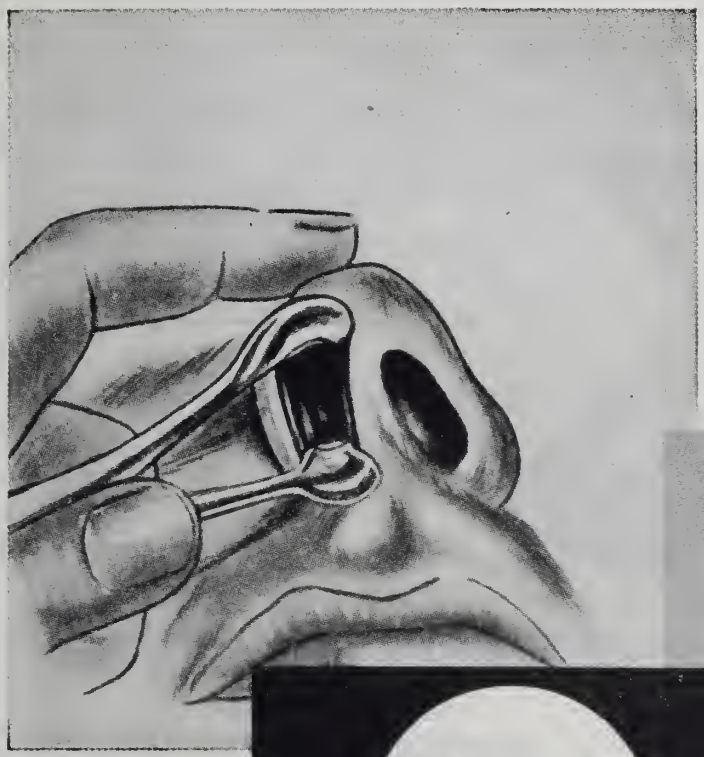
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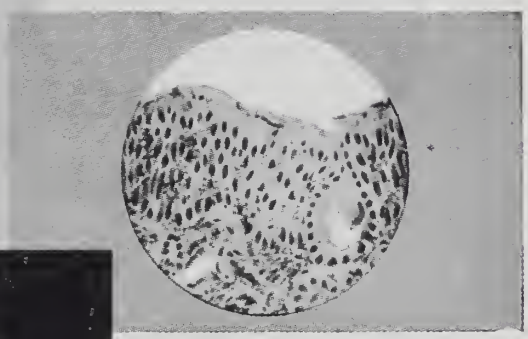


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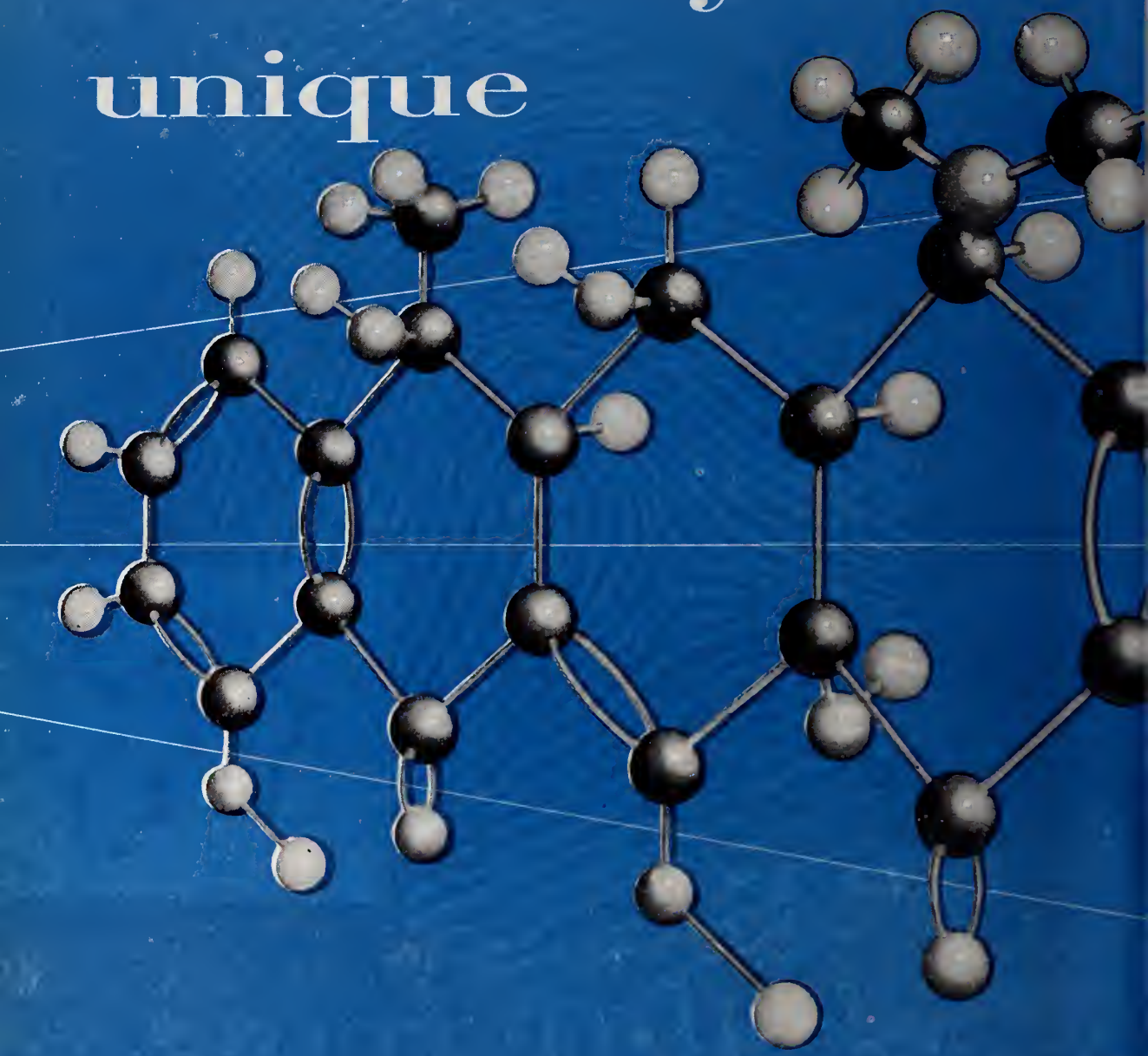


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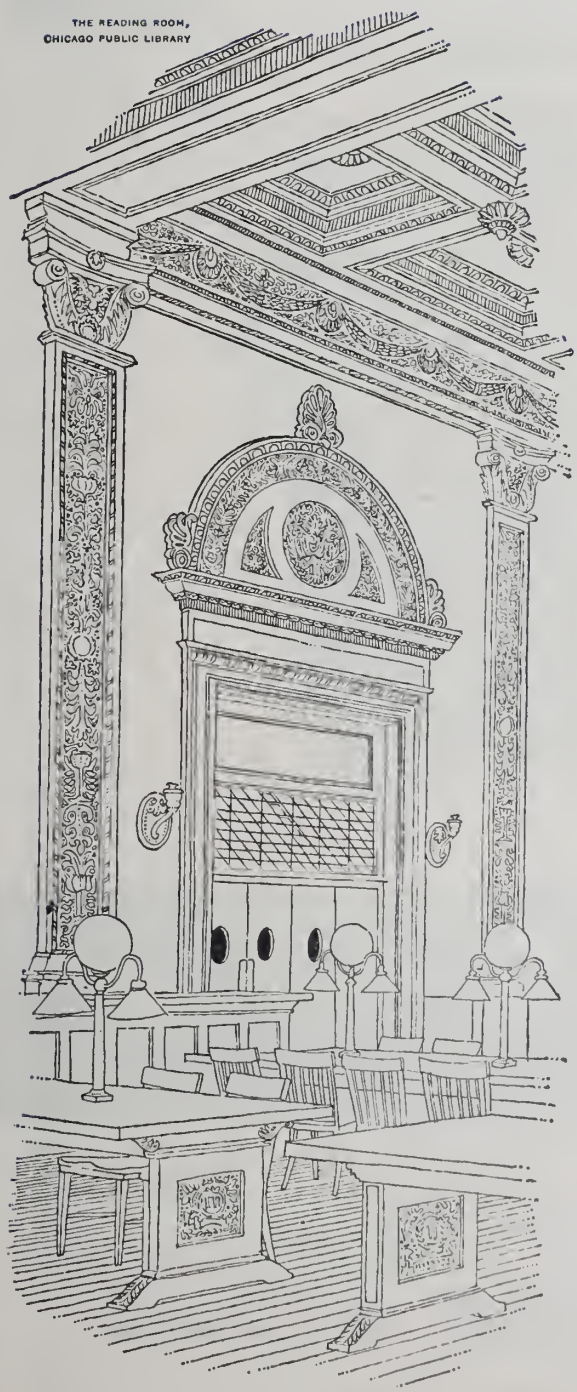
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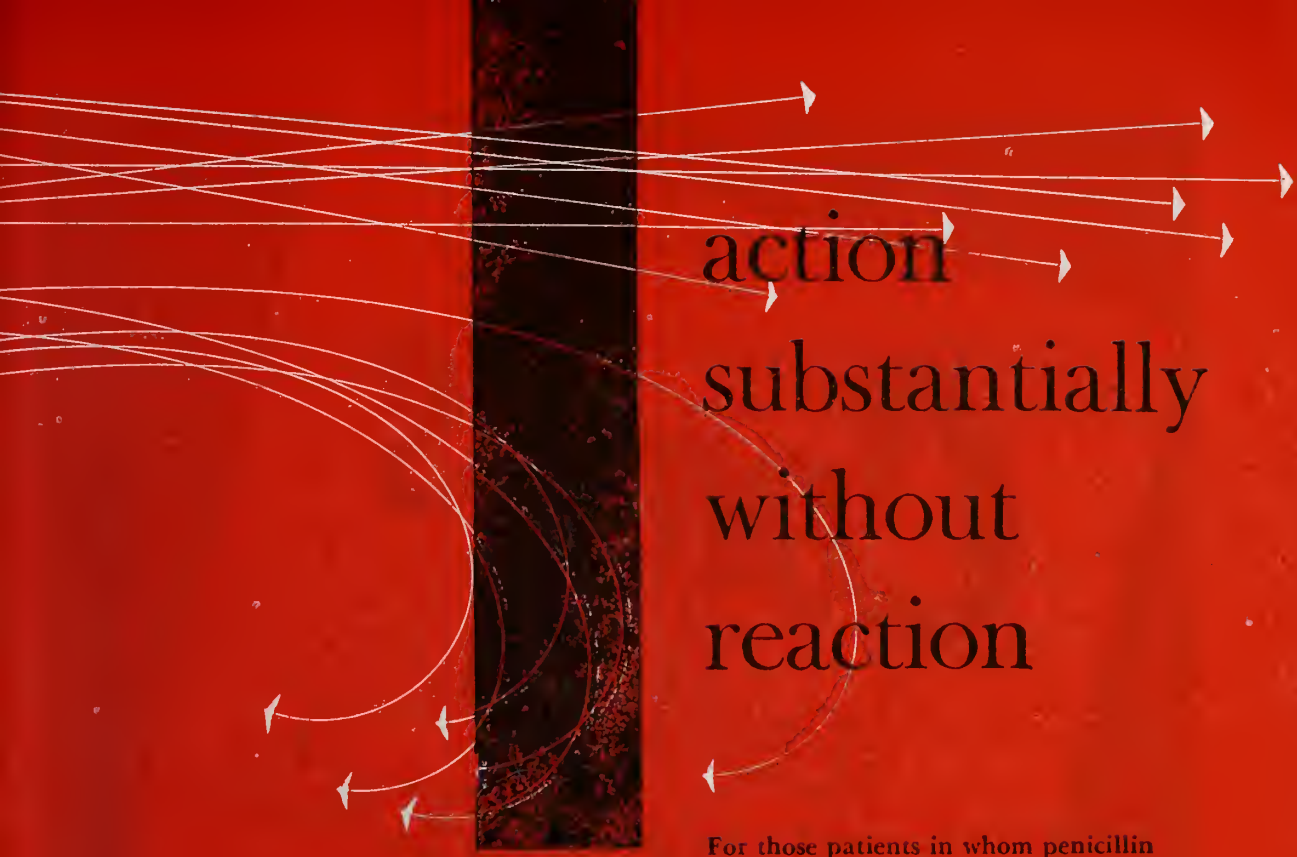
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Number 10

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PRESIDENT'S MESSAGE

MAKING MORE HOSPITAL BEDS AVAILABLE

With the marked increase in enrollment in voluntary hospital plans more people are using hospital beds. This creates an acute shortage of beds. The situation is of grave concern both to the medical profession and hospital authorities. Our medical society through its Hospital Advisory Committee is endeavoring to solve this problem.

Meetings are being held between members of this committee and representatives of the New Jersey Hospital Association to formulate plans for making more beds available for emergencies and for patients who are acutely ill.

The proposed plan will follow these lines. Every county medical society will be asked to establish or activate a Hospital Advisory Committee whose chairman will be a member of the Hospital Advisory Committee of The Medical Society of New Jersey. It will be suggested that a hospital inter-relationship committee be appointed in every hospital consisting of members from the senior and junior medical staffs. At regular intervals, a list of the patients of each physician, the admitting diagnoses and their length of stay in the hospital will be furnished the committee by the administrator or superintendent of the hospital. The length of the patient's stay and the reason for admission will be reviewed. The referring physician will be notified if the stay in the hospital has been too long or the admission unnecessary. Many

physicians will correct the abuse when reminded of it. If they do not do so, other methods will be employed.

Too many patients, especially those covered by a hospital plan, wish to remain as long as possible in the hospital. Some physicians refer cases to the hospital for minor conditions which might have been treated just as effectively at home. It will be the function of the hospital inter-relationship committee to remind the attending physician that these practices are creating the bed shortage and that it will be to his advantage to correct them if he hopes to have a bed available for his use at some future time.

It will be interesting to study the experience of the Blue Cross Plan of New York in their new experiment with extending coverage at home for patients after they have left the hospital and are convalescing. If this is successful, the procedure will help relieve this distressing situation.

Utilization of the Visiting Nurses and the Homemakers Services will provide convalescent care amid much happier and more pleasant home surroundings.

Every member of our Society must realize that the problem of making more hospital beds available rests entirely with himself. He must not complain when he is unable to obtain a bed immediately for a sick patient or has to delay elective surgery for a long period of time, if he will not enter into the program which our Hospital Advisory Committee is endeavoring to establish in every hospital in New Jersey. This is another opportunity, Doctor, to serve your community.

Harrold A. Murray, M.D.

SAMUEL ALEXANDER 1888-1952

It was, perhaps, appropriate that when his time came, Sam Alexander died while attending a meeting of his County's Board of Freeholders. If he had had any choice in the matter, he would probably have wanted to go with his boots on. For a quarter of a century he served his county as one of its Chosen Freeholders. He pretty well lived out the gospel of community service. The list of those services is long and this is not the place to recite them. He was president of a bank, of his community's Board of Health, of the Bergen County Health and Sanitary Association. He was an enormously valuable member of the Y. M. H. A. of Bergen County. He was not afraid to go into politics, for he realized thirty years ago what most of us are just recognizing now, that if we citizens want to keep politics clean, we must go into it ourselves. The people of Bergen County liked him—a fact which will not surprise any member of The Medical Society of New Jersey. He repeatedly ran for office during a period of 30 years. He was never defeated.

The fine hospital at Bergen Pines is a real memorial to Sam Alexander. That new wing was the great interest of his life during the last few years. Happily, he lived just long enough to see it dedicated.

During the difficult end-of-the-war year, 1945 to 1946, Sam Alexander was President of The Medical Society of New Jersey. He was a dynamic and vigorous officer. He attained that position after having served his county medical society in many offices and having labored on our own Welfare Committee and our Board of Trustees. He was one of the principal architects of our state's Uniform Medical Practice Act.

In these days of specialization, it is good to see a general practitioner attain such distinction. From some secret well

of energy, he tapped the resources needed to make a good doctor, a good official, a good citizen, a good statesman. If anybody ever awarded prizes for real "all-round" citizenship, Sam Alexander would be in the blue ribbon class. He was a credit to his profession and to our Society. His soul must have been a restless one, for he was always engaged in the good fight. May he, at last, rest in peace.

THE AMENDED FOOD AND DRUG LAW

Public Law 215, commonly known as the Durham-Humphrey Bill, is now in effect. It has day by day meaning for every practitioner, and it is hoped that our county societies will devote some time at meetings early this fall to giving information about this new law. The local pharmaceutical society might well be invited to participate in such a session.

The law has the primary mission of protecting public health by making clear which drugs can safely be sold direct to the public and which can be dispensed only upon prescription. It sets up a definition of dangerous drugs which must be restricted to prescription sale. Drug manufacturers will be required to label all such products with the legend: "Caution: Federal law prohibits dispensing without prescription."

Intent of the bill is to eliminate confusion in the labeling of drugs so that retail pharmacists will be able to tell from the package whether a drug requires a prescription. The law restricts to prescription sale any drug which "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug."

This definition is interpreted by the Food and Drug Administration to include, as unsafe, drugs for serious diseases which cannot be treated effectively by the layman. An example would be penicillin, which is nontoxic but which requires expert knowledge for effective use in such diseases as pneumonia.

Refilling of prescriptions for the restricted drugs without the doctor's consent is prohibited. But the pharmacist is relieved of responsibility for checking with the doctor when selling a drug that is not required to bear the "caution" notice. Such drugs, which do not require a prescription for the first sale, may be sold across the counter in the original package or as a refill of a prescription, *without further authorization by the doctor.*

The new law also legalizes telephoned prescriptions for all drugs.* Oral prescriptions for restricted drugs, however, must be reduced promptly to writing and filed by the pharmacist.

The new law allows druggists to refill any prescription for a simple home remedy without securing the doctor's approval. Last year more than 389,000,000 prescriptions of all kinds were filled by U. S. retail druggists. In New Jersey alone, pharmacists filled about 12 million prescriptions in 1951.

A thorough discussion of the many facets of Public Law 215 would thus seem to be a logical item on the agenda of any county medical society this fall. An attorney who has familiarized himself with the Durham-Humphrey bill would be a welcome guest at a meeting devoted to discussion of this amendment. Doctors have a right to look to their county societies for information on such subjects.

* The rules about narcotics have not been changed, however.

ORIGINAL ARTICLES

EARLY MEDICAL SCHOOLS OF NEW JERSEY

FRED B. ROGERS, M.D., Trenton, N. J.

The current interest in founding a medical school in New Jersey reflects the fond but not original hope of many of its citizens. Committes recently appointed by the State and by The Medical Society of New Jersey are now considering the possibility of establishing such an institution in affiliation with Rutgers University, the State University of New Jersey.

The right to grant medical degrees was vested by royal charter in our colonial colleges, Princeton and Rutgers,* and by later legislation, the same right was given to The Medical Society of New Jersey. Contrary to popular belief, there are now no laws in New Jersey which prohibit human dissection or studies on animals (each essential to medical education and research). A review of the advances contributed to medical training and practice in the past by The Medical Society of New Jersey and the early efforts shown by the colleges in the State gains interest in view of the current project.

In its earliest years, New Jersey had a few citizens who had received medical education in Europe. The profession was composed chiefly of practitioners trained by the preceptor-apprentice system. During the French and Indian Wars, association with British medical officers (who accompanied the troops and established military hospitals) served to raise the standards of local physicians. This stimulus was soon followed by the organization of a Medical Society for the Colony of New Jersey. This was the first of its kind in America. On July 23, 1766, seventeen physicians met at New Brunswick to establish this body whose purpose was to improve "the low state of affairs into which the practice of medicine has fallen".

Soon after the organization of our medical society, a change for the better took place in medical education. One of the Society's first acts was to ordain that no student be taken as apprentice unless he had a knowledge of Latin and Greek. Also no member of the Society was permitted to take an apprentice for less than four years, three of which had to be spent with the preceptor and the fourth at a medical school in Europe or America. In 1771 the Society petitioned the Colonial Legislature to enact a bill "regulating the practice of medicine". This bill was passed the following year and provided for the licensing of physicians by the Supreme Court following an examination before a board of qualified physicians. In 1816, an act authorized the formation of District and County Societies which had the power to examine candidates for medical licensure. Successful candidates were given licenses by the President of the Medical Society, authorizing them to practice anywhere in New Jersey. Finally, the authority to award the degree of *Medicinae Doctor* was granted to the Society in 1825. This right, which was exercised for many years thereafter, may still be used according to Chapter XIV of the present Constitution of The Medical Society of New Jersey.

The earliest formal medical instruction in New Jersey was a series of lectures and cadaver demonstrations given by Dr. Thomas Wood at New Brunswick in 1752. In 1790 a similar course of lectures was presented by Dr. Paul Micheau at Elizabeth. Two years later, in 1792, Dr. Nicholas Romayne initiated the first of three incidents concerning a medical school in affiliation with Rutgers.* On two of these occasions such a professional school was actually a part of its working organization.

Because of opposition by the trustees of Columbia College† to a medical school which Dr. Romayne had founded in New York City, the

* Then known as Queen's College.
† Formerly known as King's College.

latter petitioned the trustees of Queen's College in New Jersey to grant authority to his undertaking. This was done after a committee studied the possibility of establishing a professorship of Physic at New Brunswick and a suitable faculty to grant medical degrees. In 1792, the trustees of Rutger's* conferred the degree of M.B. on three candidates, and the honorary degree of M.D. on four well-known physicians. In the following year, medical graduation continued with the conferring of M.D. degrees on six candidates and the honorary degree on two medical professors. This first medical school closed in 1793, when Dr. Romayne went abroad.

No medical instruction was presented at Princeton‡ during its first fifty years. In a letter dated October 24, 1795, President Samuel Stanhope Smith first considered the possibility of founding a medical school there. He advocated that by such instruction "students of medicine in the State who wish improvement in . . . important branches connected with their future profession and seek it in neighboring cities, may be saved a considerable expense by attending at Princeton".‡ This plan was communicated to The Medical Society of New Jersey which adopted a resolution approving the undertaking. In the same year a Scottish physician, Dr. John Maclean, was chosen professor of chemistry at Princeton‡ as preliminary to a more complete organization. In addition to medical practice, Dr. Maclean was to lecture on chemistry and comparative anatomy at the college. The project failed at that time, however, but was later renewed, unsuccessfully.

In 1811, Dr. Nicholas Romayne returned to his old project of a medical school in New York organized and taught according to his own ideas. This new school soon met with difficulties so he again sought an affiliation with a degree-granting institution. In 1812 he successfully petitioned Rutgers* for a new connection, the result being the formation of "The Faculty of Medicine of Queen's College in New Jersey". Seven professors were appointed and one hundred students attended the New York school that year. Twenty-one medical degrees were conferred between 1812 and 1816. Among the graduates in 1816 was Samuel Rodman Drake, the physician-poet, author of *The American Flag*. Annual reports were made by the medical faculty to the trustees of Rutgers.* By 1816, largely due to financial difficulty, medical instruction was suspended.

Interest in establishing a medical school was renewed at Princeton‡ in 1824. In that year the trustees appointed Dr. John Van Cleve to outline a curriculum of medical study. Unfortunately, he died before completing this task. In 1830, Dr. Samuel Howell was appointed professor of anatomy and physiology. For the next four years he taught these subjects to senior students and private classes of graduates. In 1834, the trustees further approved a proposed summer course of lectures by Dr. Howell and several other physicians on "the several branches of Physic and Surgery". These lectures were intended to supplement regular winter courses at medical colleges but were not presented due to Dr. Howell's death in the following year. After 1835, his chair remained vacant and Princeton's embryo medical school came to an untimely end.

The third episode linking a medical faculty with Rutgers occurred in 1826. In that year five medical professors, recently resigned from Columbia,† secured an affiliation for their own school in New York with the college at New Brunswick. This connection was called the "Rutgers Medical College". In an inaugural address delivered November 6, 1826, Dr. David Hosack, president of its faculty, praised the new institution and its benefactor, Henry Rutgers, for whom Queen's College had been renamed in the previous year. At the opening of this medical school, Colonel Rutgers established a gold medal to be awarded annually to the student presenting the best graduating address. At the commencement of 1827, the M.D. degree was conferred on twenty-seven graduates. Nine received the honorary degree. Action by the New York State Legislature that year was aimed at the New Jersey institution granting degrees to students trained in New York. This new law decreed that no diploma awarded outside the state would confer the right to practice medicine in New York.

‡ Then known as The College of New Jersey.

Following this legislation, the medical college declined steadily. In 1832 the last medical degrees were granted in course, and three years later the last honorary degree.

After the closing of the Rutgers Medical College in 1835, little concerted effort was made toward the establishment of a medical school for New Jersey. As late as 1901, however, President Francis Patton of Princeton favored the introduction of courses in anatomy and physiology there. This he advocated "so that those who desire may have . . . in senior year the full equivalent of one year of professional study in medicine".

Recent renewal of interest in establishing a medical school in New Jersey has led to serious consideration of such a possibility at the present time. The pioneer contributions to medical education made by The Medical Society of New Jersey and attempts in the past to found medical colleges at Rutgers and Princeton offer encouragement that a medical school for New Jersey may become a reality in the near future.

Donnelly Memorial Hospitals

DIAGNOSIS AND MANAGEMENT OF ACUTE ARTERIAL OCCLUSION *

Nathan Frank, M.D., Jersey City, N. J.

Acute arterial occlusion in the extremities is a true emergency. Confronted with this catastrophe, the clinician must answer six questions: (1) Is this embolism or thrombosis? (2) If it is embolism what is the source of the embolus? (3) Is this arterial or venous occlusion? (4) Exactly where is the embolus? (5) Shall the treatment be surgical or medical or both? (6) What is the prognosis relative to the patient and the extremity?

EMBOLISM OR THROMBOSIS?

Embolism by definition is arterial occlusion by a foreign body, usually a thrombus from some distant focus. In most embolisms in the extremities, the source of the embolus is the heart—usually the left side. Haimovici[1] (who has reported the largest single series) found the heart to be the source of the embolus in 96 per cent of 330 cases. The forms of heart diseases likely to give rise to intracardiac thrombi are myocardial infarction, rheumatic heart disease, acute and subacute bacterial endocarditis and arteriosclerotic heart disease. Frequently auricular fibrillation is present. In Warren and Linton's[2] series of 110 cases, two-thirds of the cases of fibrillation had rheumatic heart disease and one-third had arteriosclerotic heart disease. Less common cases of embolism are dislodgement of atheromatous plaques in the aorta, blood clots from thrombosed pulmonary veins and thrombi from the systemic veins entering the left heart through a patent foramen ovale or interventricular septum and producing paradoxical embolism. To these, Gross[3] has added thrombi from a closing ductus arteriosus. It is possible that emboli (made up of fragments of tumor) may invade the large arteries or, more logically the pulmonary veins, become detached and lodge in the periphery. That this actually occurs is shown in the interesting case reported by Groth,[4] in which a sarcoma of the right hip traveled to the lung as a venous embolism and from there, at a later date, became an embolism to the left femoral artery. From here, it (and its very long propagating thrombus) were removed surgically and the leg was saved. Pathologic examination of the amputated right leg, a specimen of tissue from the lung and the embolectomy specimen from the left femoral artery showed identical tumors.

The determination of whether the arterial occlusion is due to embolism or thrombosis is of paramount importance. The treatment is

* Read May 19, 1952, at the Annual Meeting of The Medical Society of New Jersey.

1. Haimovici, Heinrich: Angiology, 1:20 (January 1950).
2. Warren, R., and Linton, R.: New England Journal of Medicine, 238:421 (March 1948).
3. Gross, R. E.: American Journal of Diseases of Children, 70:61 (July 1945).
4. Groth, K. E.: Surgery, 8:617 (December 1940).

radically different. To make a diagnosis of embolism one should be able to identify the source. In most cases, there is some primary form of heart disease—usually rheumatic heart disease associated with auricular fibrillation. Certainly, this will be true in young people, particularly, when there is no reason to suspect myocardial infarction or when there is a long history of chronic cardiac invalidism. This will hold true also in older persons if auricular fibrillation is present. In older patients, the following finding suggests thrombosis: evidence of *arteriosclerosis* as manifested by a history of previous long standing intermittent claudication, poor to *absent pulses* in the uninvolved extremity, *calcification* of the vessels seen on soft tissue roentgenograms and a long history of diabetes or hypertension. Another helpful bed-side observation is that the embolism is frequently followed by motor paralysis or paresis of the extremity. This does not occur in thrombosis, because then the collateral circulation would have more opportunity to develop. It is a fallacy to base the differential diagnosis on the suddenness of onset. Acute onset occurred in only 69 per cent of the Massachusetts General Hospital series[2] and in 80 per cent of Haimovici's cases.[1] Thus, at least one out of every five will develop symptoms of arterial insufficiency insidiously. Peripheral artery thrombosis can and does occasionally have an abrupt onset. Pain although frequently present, may not be. In 22 per cent of Haimovici's cases,[1] the patients had sudden numbness and coldness without initial pain.

The other condition that in rare but significant cases must be differentiated from embolism and thrombosis is acute thrombophlebitis. As shown by Leriche and Kunlin,[5] Danzis,[6] Edwards,[7] Ochsner and DeBakey[8] and Fontaine and Forster,[9] massive blockage of the deep venous spaces of the leg may throw the arteries into such a degree of spasm that the palpable pulses can disappear. A suggestive line of skin demarcation can ensue and even lead to gangrene. Careful inspection of the limb for venous engorgement, lack of muscular paralysis and anesthesia, and the use of an oscillometer to detect the presence or absence of oscillations in the calf will make this differential diagnosis.

LOCATION OF THE EMBOLUS

Where the embolus is, frequently determines the course of treatment. Location also has significant prognostic value. Localization of the embolus is seldom difficult. Emboli most often lodge at bifurcations where the caliber of the artery is suddenly reduced. The arterial occlusion is just distal to the point where normal pulsations are noted. This is best determined by careful testing with the oscillometer. Extreme tenderness over the region of occlusion is common. The line at which the temperature of the skin changes from low to normal is of importance. This can be determined by passing the back or side of the hand proximally from the distal portion of the extremity. In occlusion of the popliteal artery, this line is just above the ankle; in occlusion at the bifurcation of the femoral artery, at the junction of the lower and middle third of the thigh. When the common iliac artery is occluded, the point is at the juncture of the middle and upper third of the thigh. Similar relationships between the location of the embolus and the line of sharp change in temperature is observed in the upper extremity. When arteries are paired, as the radial and ulnar or dorsalis pedis and posterior tibial arteries are, occlusion of one of them may produce only minimal changes in temperature or color, as the companion artery continues to carry blood to the distal parts. If gangrene has already ensued, amputation should be done *above* the level of absent pulsations. Prognosis of upper extremity embolism is usually favorable. Conservative management is highly successful. Embolism to the popliteal artery usually results in gangrene with either surgical or medical management or both. Embolism to the aorta (particularly in older patients) is almost always fatal because of the extensive

5. Leriche, R., and Kunlin, J.: Presse Medicale de Paris, 42:1481 (November 1934).
6. Danzis, Maximilian: Annals of Surgery, 98:249 and 98:422 (February and April 1933).
7. Edwards, Edward A.: New England Journal of Medicine, 224:189 (October 1941).
8. Ochsner, A., and DeBakey, M.: Journal of the American Medical Association, 114:117 (March 1940).
9. Fontaine, R., and Forster, E.: Lyon Chirurgie, 41:173 (February 1946).

arteriosclerotic changes and the need of general anesthesia for surgery.

TREATMENT

This is the plan of management used in most large hospitals where this emergency is not too infrequently encountered. If the occlusion has occurred ten hours or less before being seen, embolectomy is almost always recommended. Exceptions are popliteal and aortic occlusions, particularly when there are diffuse atheromatous changes. In upper extremity occlusion, a two to four hour trial period of conservative treatment (as outlined below) is tried. As a result of numerous clinical and experimental observations, ten hours has been found to be the optimum time limit for embolectomy. Occasionally, one hears of dramatic results from surgery after much longer periods of occlusion. These are the exceptions rather than the rule. If embolectomy is performed, anticoagulant therapy is instituted about four hours after surgery. Heparin and Dicumarol[10] or Tromexan[11] are started at the same time.

If embolectomy is contra-indicated the following regimen is followed: (1) elevation of the head of the bed eight inches from the floor; (2) the affected extremity is wrapped in a cotton boot or small blanket; (3) paravertebral, spinal or caudal blocks are done immediately and repeated at intervals of twelve to twenty-four hours until circulation is restored or until no further improvement is noted; (4) combined anticoagulant therapy i.e. heparin and Dicumarol[10] or Tromexan[11] is begun; (5) pain is relieved by proper analgesics. Papaverine, intermittent venous occlusion, the oscillating bed and the common sympatholytic vasodilators have not been altogether successful in our hands. Recent studies with intra-arterial administration of Priscoline[12] and similar agents have been found to give some promise but we have not had any extensive experience with this method of treatment.

10. Dicumarol is the collective registered trademark of the Wisconsin Alumni Research Foundation for a synthetic metheylene hydroxy coumarin. The word "Dicumarol" is controlled by, and is used only with permission of the Wisconsin Alumni Research Foundation.
11. Tromexan is a trade-name registered by the Geigy Company to designate their brand of ethyl biscoum acetate.
12. Priscoline is Ciba Pharmaceutical Products' trade-name for benzazoline.

SUMMARY AND CONCLUSIONS

1. The etiology, diagnosis, prognosis and treatment of acute arterial occlusion has been discussed.

2. Most acute artery occlusions occur in patients with serious heart disease.

3. The prognosis as to the survival of the extremity depends essentially on the site of occlusion and the promptness of treatment. The prognosis as to the survival of the patient depends essentially upon his heart condition and the possibility of further embolism to vital viscera.

4. In early occlusions, embolectomy is the treatment that still offers the best prognosis.

5. A regimen of conservative management has been outlined. This form of therapy is also effective in a large proportion of carefully selected patients.

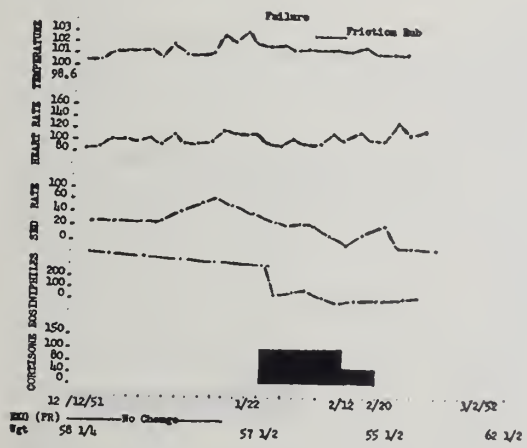
6. Success rests upon team work between the internist and vascular surgeon.

180 Bowers Street

CORTISONE AND ACTH IN RHEUMATIC FEVER *

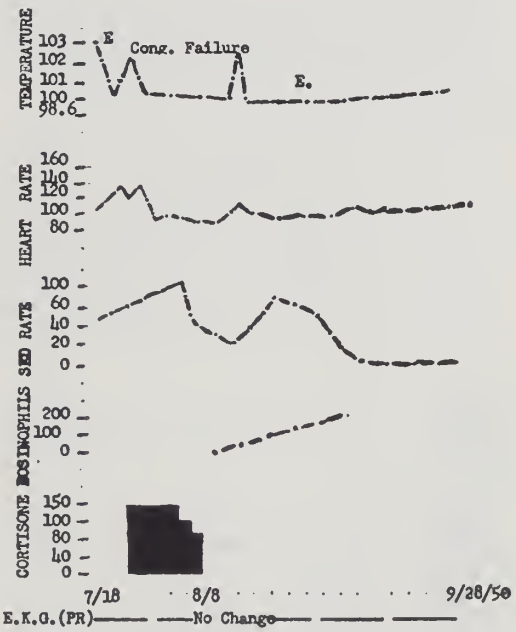
PAUL A. KEARNEY, M.D., Short Hills, N. J., and
HARROLD A. MURRAY, M.D., Newark, N. J.

The hope that ACTH and cortisone would be useful in a wide variety of conditions has largely faded. Adrenocorticotropic hormones are of value only in selected cases of rheumatic fever. As shown by Mote[1] and Barnes,[2] and in our series of 18 cases, the results of administration of ACTH and cortisone to patients with acute rheumatic fever vary with the severity of the disease, but especially according to how early in the course of the rheumatic fever these hormones are given. If they are given early in the attack, polyarticular symptoms, elevation of temperature, and increased heart rates are abolished in 1 to 5 days. Prolonged PR intervals decreased in 1 to 2 weeks. Sedimentation rates begin to fall rapidly in a week, and reach normal levels in 12 to 21 days. In two to three weeks the value for hemoglobin rises sharply and the globulin fraction of the serum protein falls to normal levels.



Age 8. Markedly enlarged heart but minimal left auricular enlargement. Question of Lutembacker Syndrome. Prior to cardiac catheterization, patient went into congestive failure which was controlled by digitalis and Mercuhydrin.† Cortisone added to patient's general improvement but did not prevent a pericarditis as evidenced by a friction rub which was elicited two weeks after hormone therapy was started. Diagnosis: mitral stenosis and insufficiency.

Massell and Warren[3] say that they have cured the disease in some patients and shortened the course in others. However, it is obvious from the literature and from our series that these hormones neither cure rheumatic fever, nor shorten its duration. ACTH and cortisone act by suppressing the manifestations of rheumatic fever. The mechanism is not clear. Some investigators feel that it produces a marked decrease of the level of non-



Age 11. Rheumatic fever at age 3 and 11. Interval period characterized by frequent epistaxis. Admitted with typical rheumatic fever associated with severe epistaxis (E) requiring blood transfusion. On third hospital stay patient went into congestive failure unresponsive to digitalis, oxygen, or Mercuhydrin.† Cortisone started on fifth hospital day. Response was dramatic and followed Wilson and Helper's criteria. Peak rise in temperature, pulse, and sedimentation rate one week after cessation of hormone therapy was a rebound phenomenon. Discharge diagnosis: mitral stenosis and insufficiency.

* Read by invitation at the Pediatric Section of the Annual Meeting of The Medical Society of New Jersey at Atlantic City, May 20, 1952.

† Mercuhydrin sodium is a trade-name for a brand of meralluride sodium. The word Mercuhydrin is registered by Lakeside Laboratories, Incorporated, of Milwaukee.

specific hyaluronidase inhibitor in the serum of patients with rheumatic fever; others[6] feel that it prevents the "altered cellular reaction" in an allergic state.

We have found, as did Wilson and Helper[4] that the count of the circulating eosinophils is probably the most useful guide in therapy with adrenal cortical hormones. They consider that treatment is inadequate unless the circulating eosinophils drop practically to zero; and that a satisfactory therapeutic response consists of a rise on the administration of either ACTH or cortisone.

Dosage: Empirical—Wide tolerance of ACTH and cortisone.

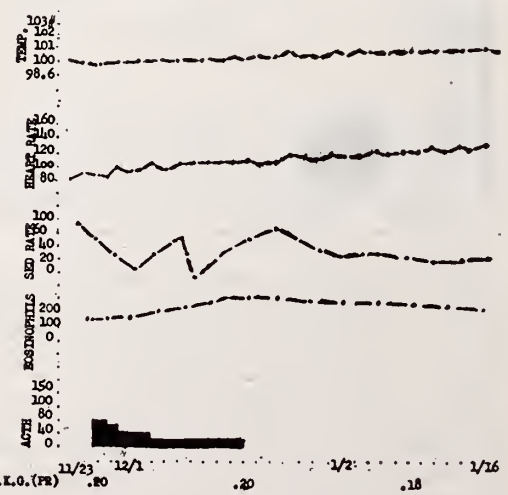
One patient given 1000 mg. in 24 hours; no side effect. ACTH divided dose—I.M. 80 mg. first two days then 60 mg. daily for 3 weeks.

Cortisone—300 mg., then 200 mg., then 100 mg. for three weeks then step-wise to decrease to 12.5 mg. daily.

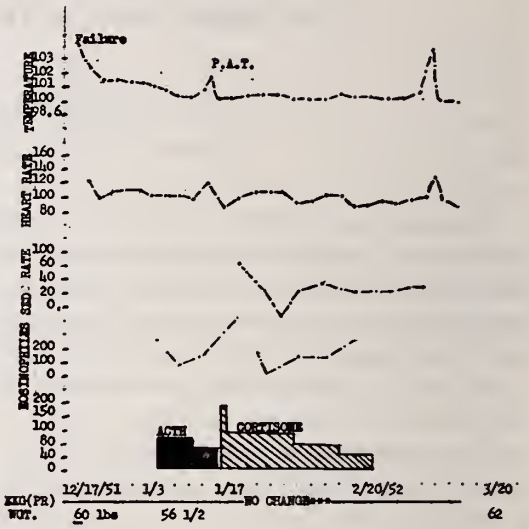
Dangers: Salt and water retention.

Not too serious. Must be watched carefully if there is incipient heart failure.

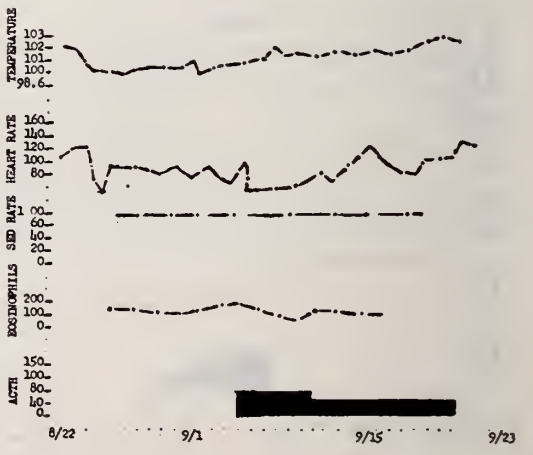
Not necessary for chemical balance studies of sodium, potassium and chlorides if blood-pressure and weight are recorded daily and if there is salt restriction. Give two Grams of potassium chloride daily. Blood counts, electrocardiogram and urine analysis are ordered weekly.



Age 11. First attack of rheumatic fever one month prior to admission. Patient discharged two months later. Pattern of the disease was seemingly unaffected by three weeks' therapy with ACTH. The hormone was ineffective in this post-rheumatic state (a subsiding carditis). Diagnosis: mitral insufficiency.



Age 12. First attack of rheumatic fever at age 8. Admitted in congestive failure which was controlled by digitalis, et cetera. ACTH started on seventeenth hospital day with observed improvement but changed to cortisone for the former seemingly induced episode of paroxysmal auricular tachycardia. Diagnosis: mitral stenosis and insufficiency.



Age 16. Admitted August 22, 1951. Died September 23, 1951. Rheumatic fever at age 8. Auricular fibrillation since age 10. This was the fourth hospital admission for congestive failure. This last admission characterized by a progressive downhill course unfesponsive to digitalis, Mercuhydrin,† and supportive medication including ACTH. Death was due to a mechanical failure. Diagnosis: mitral stenosis and insufficiency, aortic stenosis and insufficiency, and pulmonary insufficiency.

Hormone therapy is most effective in seriously ill patients; that is, in the exudative phase of the disease. It has no effect in pre- or post-rheumatic fever cases.

Side effects are minimal and reversible in short term treated (hyperadrenalism) cases.

Seemingly, hormones do not alter the duration, nor sequelae of disease, but do allow for better patient-tolerance as indicated by weight gain, general improvement and improved demeanor.

As in Kuttner's study,[7] tachycardia in the absence of fever and instability of pulse rate were the two signs of carditis that showed least response to hormone therapy.

MacEwen[8] feels the prophylactic use of penicillin 100,000 to 200,000 units before meals on an empty stomach or the use of sulfadiazine 1 Gram daily for children over 70 pounds is important in decreasing the incidence of streptococcal infections. Penicillin is superior, in that streptococcus can become resistant to sulfanilamide drugs.

Tarant[9] disagrees with MacEwen.[8] He says that rheumatic fever is hereditary and that it is not affected by streptococcal infections.

85 Woodland Road, Short Hills
624 Mt. Prospect Avenue, Newark

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2. Barnes, A. B.: Circulation, 3-770 (March 1951).
3. Massell, B. F., and Warren, J. E.: Journal of the American Medical Association, 145:133 (April 1, 1951).
4. Wilson, M. D., and Helper, H. V.: Journal of the Northeastern Society for the Study of Diseases of the Adrenals, 1:17 (March 1952).
5. Dorfman, Z. B., and Moser, F. E.: Proceedings of the Society for Experimental Biology and Medicine, 75:782 (July 1950).
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7. Kuttner, A. G.: Journal of the American Medical Association, 148:8 (January 2, 1952).
8. MacEwen, Brian: Scottish Journal of Antibiotics, 14:14 (December 1951).
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TREATMENT OF HEART DISEASE IN CHILDHOOD*

RACHEL ASH, M.D., Philadelphia, Pa.

ARRHYTHMIAS

Premature contractions are of interest primarily because of their lack of importance. They may occur in children ill with infectious diseases of various types, in which case treatment of the specific disease process is indicated. They occasionally appear in association with serious cardiac anomalies. Most frequently, extrasystoles in childhood arise from a single irritable focus within an otherwise normal heart and require no treatment. Such premature contractions resemble each other in any one lead of the electrocardiogram, thus indicating a common point of origin. Children who present benign extrasystoles of this type should be treated as normal individuals and not be restricted in exercise.

In infants with *paroxysmal tachycardia,* the rate noted in the electrocardiogram is much faster than in older individuals, usually being greater than 200 and often greater than 300. It is possible for alternate beats to be diminished in intensity and inaudible, so that diagnosis may be missed by auscultation alone. The attack often subsides spontaneously and may pass unnoticed. If tachycardia persists congestive failure may result, evidenced by cardiac enlargement, dyspnea, an enlarged liver, grayish cyanosis and perhaps some edema. Fever may be present even in the absence of infection. The condition is most frequently mistaken for pneumonia. An electrocardiogram is always indicated in infants with congestive failure to rule out possible paroxysmal tachycardia.

If the attack persists for more than 24 hours or if signs of distress appear, treatment should be instituted promptly. In my experience, digitalis is the drug of choice. It has been necessary to use quinidine sulphate only in rare cases and the parasympathomimetic drugs have

* Read by invitation, Annual Meeting of The Medical Society of New Jersey, May 21, 1952. This work is from the Department of Pediatrics, University of Pennsylvania and from The Childrens Hospital of Philadelphia.

never been indicated. Infants seem fairly resistant to the toxic effects of digitalis. A preparation of mixed glycosides may be given parenterally as a single dose of one U. S. P. unit per 5 kg (10 lbs.) body weight or digitoxin may be used orally in a dose of 0.1 milligram per 10 lbs (5 kilograms) of body weight. If necessary, one-half this dose may be repeated at 6 or 8 hour intervals until normal rhythm occurs. In severe cases, quinidine sulphate may be used in doses of 60 milligrams (one grain) every one or two hours orally until normal rhythm occurs or signs of toxicity appear as evidenced by prolongation of the QRS complex in the electrocardiogram. These two drugs may be used in conjunction with each other.

RHEUMATIC FEVER

Since the etiologic agent of *rheumatic fever* is unknown, no specific treatment is available. Treatment is symptomatic aided by rest and other supportive measures designed to conserve the energy of the individual until his own defensive mechanisms overcome the disease. One may assume that the heart is involved in every case of rheumatic fever in childhood even though there may be no clinical signs of carditis. For this reason, the child should be kept at absolute bed rest without lavatory privileges. Progressive cardiac enlargement is more likely to occur in children not kept at absolute bed rest during the period of active rheumatic infection.

Sedatives may be used as an adjunct to rest. Phenobarbital given 3 or 4 times a day in doses of 15 to 45 milligrams (¼ to ¾ grain) is valuable because of its prolonged effect. Salicylates relieve joint pains and fever although they probably have no effect on the underlying disease process. In the acute stage, acetylsalicylic acid may be given in divided doses to a total amount of 60 milligrams (1 grain) per pound of body weight per 24 hours. The dose should be decreased when symptoms have subsided. The addition of sodium bicarbonate is unnecessary. Its action in reducing the toxicity of salicylates seems to be due to increased excretion through the kidneys, thus lowering the level of the drug in the blood stream. If a low blood level seems desirable, the administration of smaller amounts by mouth would be preferable. Adequate fluids and carbohydrates should be supplied when salicylates are administered in high dosage. Signs of toxicity should be looked for—notably deep, rapid respirations. If salicylates are poorly tolerated (or fail to produce the desired affect) amidopyrin may be used in doses approximately one-fifth that of salicylates, taking the precaution to check the white blood cell count periodically for evidence of agranulocytosis.

Penicillin or other antibiotic drugs may be used for the associated infections such as acute pharyngitis or bronchitis. These antibiotic agents have no influence, good or bad, on the rheumatic process itself.

Since rheumatic fever is a chronic disease of long duration, a well balanced diet should be provided, pleasing to the child, adequate in calories, of high vitamin content, particularly vitamin C. Iron does not influence the associated anemia, which improves spontaneously when the disease subsides. Following repeated or severe nose bleeds, transfusion may be indicated, preferably given as a slow, intravenous drip in amounts of 50 to 75 cubic centimeters daily, using packed or sedimented red blood cells.

CONGESTIVE FAILURE

When congestive failure is present, measures to conserve the energy of the child should be intensified with the aid of special nursing. The child should not be allowed to feed himself. Salt free fluids and minced foods should be administered in frequent, small amounts. Sodium salts, including sodium salicylate and sodium bicarbonate should be restricted. The use of oxygen at the first sign of respiratory distress is important. All nursing procedures should be synchronized so that the child is not disturbed and the oxygen tent not opened at intervals of less than one hour or more. A minimum of 10 liters of oxygen per minute should be used. In the presence of intense respiratory distress a flow of 16 to 20 liters per minute may be necessary. Morphine sulphate in doses of 0.5 to one milligram (1/60 to 1/120 grains) per 10 pounds of body weight

is the most effective drug to allay restlessness. Morphine and amidopyrine should be used cautiously in the presence of edema since they are antidiuretic substances.

Mercurial diuretics are of value in the presence of liver enlargement and dyspnea. Mercuhydrin or Mercuzanthin† may be given intramuscularly or intravenously in doses of 0.5 to 1 cubic centimeter; Thiomerin‡ subcutaneously, in similar doses. If given intramuscularly, equal parts of one per cent procaine hydrochloride may be added to relieve the pain of injection. Intravenous administration of mercurial drugs is not advisable if the serum protein is low. Theobromine calcium salicylate (Theocalcin§) in doses of 0.5 to one Gram three times a day may be of value in mild stages of congestive failure.

Congestive failure due to rheumatic infection often fails to respond to digitalis. At times, however, digitalis may improve cardiac efficiency during a critical period. It should be used without hesitation in a child who fails to respond to rest, oxygen, sedation and diuretics. It may not be possible to maintain a therapeutic effect if the child fails to recover from the rheumatic process spontaneously. Since rheumatic children are often unduly sensitive to digitalis, the toxic dose may be less than the therapeutic dose. For this reason (except in extreme cases) the drug should be administered gradually over a period of 36 to 48 hours. *The child should be examined for signs of toxicity before each dose is given.* Electrocardiographic control is not necessary. *Careful auscultation will disclose the changes that indicate toxicity* . The drug should be discontinued if marked sinus arrhythmia, extrasystoles or bradycardia make their appearance. Although the therapeutic dose will vary greatly in individual cases, the average total dose may be calculated as 0.1 Gram or one U.S.P. unit of a standard digitalis preparation per 10 lbs. body weight. Equivalent doses of glycoside may be used. Many rheumatic children who have recovered from acute congestive failure do not need to be maintained on digitalis. If needed, the maintenance dose is approximately one-tenth the digitalizing dose. Daily examinations should be made to detect signs of toxicity and the maintenance dose should be varied accordingly.

CONVALESCENCE

After recovery from the acute stage, the rheumatic child will still require a long period of bed rest and convalescent care before normal activities may be resumed. The emotional as well as the physical needs must be satisfied. The possibility of recovery should be stressed. The child should be given an opportunity to discuss his hidden fears and anxieties. Home teaching should be provided, together with occupational and diversional therapy to provide substitutes for the physical pleasures the child has been forced to renounce. Admission to a sanatorium for convalescent care is often advisable.

Complete bed rest should be continued until all clinical and laboratory manifestations of rheumatic fever have disappeared or have reached a stable level. Return to a normal life should be gradual. When the child is permitted to return to school, it is wise to start with parttime attendance. Measures to maintain the general health should be enforced: adequate sleep, proper diet and clothing, avoidance of exposure to stormy weather, freedom from emotional disturbances. When free from active infection, the child with rheumatic heart disease should be permitted to find his own level of physical activity. Competitive sports and gymnastics that require an unaccustomed form of exertion are not recommended. Otherwise, exercise including dancing and all types of games should not be restricted, provided that these activities are not continued to the point of producing fatigue or shortness of breath.

Rheumatic children should remain under periodic medical supervision. They should receive prompt treatment with antibiotics for any acute infection. Following such infections, convalescence should be prolonged sufficiently to make certain that no recurrence of

† These are proprietary names. Mercuhydrin is U.S.P. meralluride as prepared by Lakeside Laboratories and Mercuzanthin is the trade name used by the Campbell Pharmaceutical Company for a brand of U.S.P. mercophylline.

‡ Thiomerin is the trade-name which the Campbell Pharmaceutical Company gives to its brand of mercaptomerin sodium.

§ Trade-named by Bilhuber-Knoll Corp.

rheumatic infection has occurred. Prophylactic medication is recommended for those with rheumatic heart disease in the hope that the incidence of recurrences may be lessened by preventing hemolytic streptococcal infections. Sulfamerazine may be taken throughout the year in daily doses of 0.5 Gram if below 70 lbs. in weight; twice daily, if over this weight. The white blood cell count should be checked frequently for the first 3 weeks. If during this period it is found that the child can tolerate the drug, he may be followed subsequently at 6 week intervals, checking the white blood cell count at each visit. Oral penicillin may be used in doses of 100,000 units twice daily, given at least one-half hour before breakfast and before the evening meal.

TONSILLECTOMY

In the experience of physicians who have followed large groups of rheumatic children, tonsillectomy has produced occasional exacerbations of the disease, sometimes fatal, if the rheumatic infection was still active when tonsillectomy was performed. If tonsillectomy is indicated because of chronic disease of the tonsils, the procedure should be carried out when the rheumatic process is inactive and the sedimentation rate normal. It is well to administer penicillin or other antibiotics prophylactically before and after tonsillectomy, dental extraction or other operative procedures.

ADRENAL CORTICAL HORMONES

The decision as to the value of corticotropin (ACTH) and cortisone in the treatment of rheumatic fever is still in doubt. Since the untoward effects produced by effective doses are often serious, treatment with these agents preferably should be administered in a hospital where the child can be kept under constant observation. Acute symptoms such as fever, arthritis and toxicity, as well as laboratory signs of infection subside quickly following the use of these substances. The natural duration of the illness, however, is not shortened nor are recurrences prevented. Pre-existent heart damage is not modified. Children with acute pericarditis often improve dramatically following the use of ACTH or cortisone. Whether permanent cardiac damage or death can be prevented is still a subject of controversy.

In general the dose of ACTH is one-half that of cortisone. A relatively high initial amount is used (80-100 milligrams ACTH or 150-200 milligrams of cortisone daily in divided doses); gradually reducing the dose over a period ranging from one to three weeks, depending on the severity of the infection and the results obtained. Rebound phenomena are not uncommon, i.e. the recurrence of symptoms after cessation of therapy. These may disappear spontaneously or treatment may need to be continued with smaller doses. Signs of hyperadrenalism occur in practically every patient in varying degree—moonface, acne or furunculosis, abdominal distention, adiposity, striae, hirsutism, fluid retention. These disappear when treatment is stopped.

From my own experience in treating heart disease in children, I have concluded that ACTH and cortisone need not be used in the child with rheumatic fever who shows no undue toxicity and presents no clinical signs of active heart disease. Steroid hormones should probably be used in the child with acute carditis, particularly with pericarditis, who does not respond promptly to rest, salicylates, oxygen, diuretics and digitalis. It may perhaps be used as a first procedure in such cases if the involvement is exceptionally severe. The child should be carefully observed for signs of fluid retention which may lead to acute pulmonary edema requiring heroic emergency treatment. Such fluid retention can be minimized by restriction of salt, the prompt use of diuretics if indicated and reduction in dose of the steroid hormone. Whether ACTH or cortisone should be used in the treatment of the child whose illness shows a degree of severity between these two extremes is a matter of individual judgment. Certainly their demonstrated value is not so great as to warrant a father mortgaging his home or insurance policy and jeopardizing the financial security of the entire family in order to ensure treatment with these expensive substances.

CARDIOVASCULAR ANOMALIES

Children with *cardiovascular anomalies* may be divided into three groups. In groups 1 and 2, the arterial oxygen saturation at birth is normal and the infants are not cyanotic. Individuals in group 1 have no defect through which admixture of venous and arterial blood may occur. In group 2, however, there exists an uncomplicated septal defect or patent ductus through which blood passes normally from the arterial to the venous side. With the development of increased pulmonary resistance, pressure in the pulmonary artery rises and there may be a reversal of shunt from the venous to the arterial side with the appearance of late or terminal cyanosis. In group 3 the individuals are born with hearts so malformed as to ensure the primary mixture of venous-arterial blood within the arterial vessels. These infants all have anoxemia at birth, but not always of a degree sufficient to be detected as cyanosis. With time, however, they all become cyanotic.

Insofar as possible, babies with cardiovascular anomalies should be treated as normal infants. They should receive immunizations against diphtheria, pertussis and tetanus at the proper time. Most non-cyanotic babies, and many of those who are cyanotic will develop and grow normally. In non-cyanotic infants, the seriousness of the anomaly bears no relation to the intensity of the thrill or murmur; it is more closely related to the size of the heart. An infant with an intense thrill and a loud murmur heard over the entire chest may have a heart of normal size and function, whereas another infant with a barely audible murmur may present a greatly enlarged heart with signs of congestive failure.

In cyanotic infants incapacity is more closely related to the degree of anoxemia than to the size of the heart. Infants with a tight pulmonary stenosis and markedly inadequate pulmonary blood supply may be greatly handicapped even though the heart is small.

Treatment during the neonatal period for the majority of babies who are born blue can be carried out most effectively in the hospital in which they are born. Most infants with cyanosis at birth suffer from anoxia due to pulmonary insufficiency with or without associated hemorrhage of the brain and injury to the respiratory center. Since such infants need constant oxygen and rest, it would be hazardous to transfer them to another hospital. Some cyanotic babies suffer from anomalies other than cardiac—diaphragmatic hernia, tracheo-esophageal fistula with pneumonia, massive cysts or agenesis of the lung and others. Only a minority of babies who are cyanotic at birth have cardiac anomalies. Cyanotic babies with congenital heart disease may be divided into two groups—those with and those without adequate pulmonary circulation. Only those without adequate pulmonary circulation can be helped by surgery. Cyanotic newborn infants with large hearts and prominent vascular shadows are inoperable and there is nothing to be gained by transferral to another hospital.

When it seems certain that no pulmonary insufficiency exists and that no condition other than a cardiac anomaly is present to account for cyanosis, the cyanotic infant should be tried out of oxygen. If he is able to exist out of oxygen, to take feedings and to gain weight, studies at a special diagnostic center may be deferred until the infant is 3 or even 6 months of age. Even if an operable lesion is present, it is wise to defer operation as long as possible. Provided no undue degree of polycythemia develops, *operation is not indicated so long as the infant is able to grow and develop, even if such growth and development is slower than the average.*

Severe attacks of increased cyanosis and dyspnea may be relieved by placing the infant in the knee-chest position and providing access to fresh air or oxygen. The parenteral administration of morphine sulphate in the dose of 0.5 to 1 milligram per 5 kilograms of body weight (1/120 to 1/60 grain per 10 pounds) is of value.

Infants with cardiovascular anomalies tolerate infections poorly. They should be given high doses of antibiotics at the onset of any febrile illness. Since diseased teeth and gums form a ready focus of infection for the development of endocarditis children with cardiovascular anomalies should receive dental

supervision from the time of appearance of the first teeth. An antibiotic should be administered preceding and following the extraction of teeth or after tonsillectomy. These children should not have their exercise restricted unduly, but should be permitted to find their own level of physical activity. In spite of startling murmurs and cardiac enlargement they are often able to lead a normal life.

With the advent of surgical procedures for the relief of congenital cardiovascular anomalies it has become important for physicians to learn to recognize lesions which may be suitable for operation.

AORTIC ANOMALIES

Anomalous vessels arising *from the aortic arch* or a vascular ring encircling the trachea or esophagus are not indications for operation, since such anomalous structures may exist without undue constriction and without symptoms. It is possible, however, for such vessels to exert sufficient pressure on the trachea and esophagus to produce a degree of respiratory distress and dysphagia that may lead to death in infancy. Children who present such symptoms should be referred for roentgenographic study. If the diagnosis is confirmed, such anomalous vessels can be severed or displaced surgically to relieve pressure.

Coarctation of the aorta consists of a congenital stenosis of this vessel, usually located in the descending arch below the point of origin of the subclavian artery. The diagnosis can easily be made by any physician since the pathognomonic finding is hypertension in the arms associated with low blood pressure in the legs and absent or diminished pulsations in the abdominal aorta, femoral, popliteal and dorsalis pedis arteries. Children with coarctation are usually well built, athletically inclined and noncyanotic. Only 25 per cent of such individuals may be expected to live a normal length of life. The remainder die of rupture of the aorta or a cerebral vessel, bacterial endarteritis or heart failure.

The operative procedure consists of resection of the stenosed area followed by anastomosis of the upper and lower portions of the severed aorta. Operation is preferably performed in youth, first, because of the relatively early death in at least half the individuals with coarctation; second, because of the greater elasticity and pliability of the vessels at this age period. I consider 9 years the optimum early age for operation although I would not hesitate to refer younger children in the presence of marked cardiac enlargement, marked hypertension or headaches associated with dilated vessels of the neck. It is important that interrupted sutures be used in the surgical repair of coarctation in children since otherwise the anastomosed area will not grow and a secondary coarctation will develop. Aortic grafts are not suitable for children since they do not grow.

Patent ductus arteriosus may be recognized by auscultation alone, since the pathognomonic finding is a continuous murmur below the left clavicle, the "machinery murmur". Children with persistent patency of the ductus arteriosus are not cyanotic. About half of them are poorly nourished. Three-quarters of these children may be expected to die in early or mid-adult life of rupture of the ductus, bacterial infection or congestive failure. Because of the early development of sclerotic changes within the walls of the pulmonary vessels, operation is preferably performed in childhood. In the hands of a skilled vascular surgeon, ligation or severance of a patent ductus in childhood carries little risk. I prefer to refer children for operation at about 4 years, when they have usually passed the "negativistic" age and can undergo the experience without undue emotional trauma. Technically, the operation can be performed at a much earlier age if necessary. At the Children's Hospital of Philadelphia a patent ductus has been ligated in 3 infants aged 5 months because of the presence of cardiac failure.

INADEQUACIES OF PULMONARY CIRCULATION

It is only for cyanotic individuals with inadequate pulmonary circulation that satisfactory operations have been devised. Neither the presence nor the absence of a murmur or a thrill is of value in differentiating the operable from the inoperable cyanotic child. The differential diagnosis can be made only by careful roentgenographic examination, with the occasional aid of angiocardiography or intracardiac catheterization. Two types of operation are available, (1) anastomosis between a pulmonary artery and an arterial vessel; (2) a direct at-

tack upon the stenotic area. Cyanotic individuals suitable for an anastomosis operation not only must have diminished pulmonary circulation, but in addition there must be an associated anomaly which permits the passage of venous blood into the arterial stream. If such mixed blood is shunted from an arterial vessel into the pulmonary artery, there is delivered into the lungs an increased amount of red blood cells containing reduced hemoglobin which may be exposed to the oxygen of the alveolar air. In addition, a persistent septal defect should be present to act as a safety valve and prevent postoperative congestive failure. The most favorable anomaly for an anastomotic operation is tetralogy of Fallot. The component features are pulmonary stenosis, as a result of which an inadequate supply of blood is shunted into the lungs associated with a dextroposed aorta overriding a ventricular septal defect through which venous blood can be shunted into the aorta. The ventricular septal defect serves also as a safety valve following operation. The risk of anastomosis has proved to be minimal between the ages of 3 and 14 years. It is not always possible, however, to wait 3 years. An infant who cannot live out of oxygen or who becomes so exhausted when feeding that he cannot take in an adequate number of calories is in so severe a state of anoxemia as to warrant early surgery. Polycythemia above 7 million as a potential cause of cerebral thrombosis and hemiplegia; hemiplegia due to such a cerebral accident; bleeding phenomena due to anoxemia; a heart that is beginning to enlarge—all of these are indications for early surgery. Children should not be referred for operation merely because of cyanosis and an operable lesion, but only if they are definitely incapacitated.

In about 30 per cent of individuals with tetralogy, the site of the stenosis is at the pulmonary valve; in the remaining cases it is in the infundibular region. Physiologically, a direct attack on the pulmonary valve (valvulotomy) may be the preferable operation in cases of valvular stenosis, provided it can be proved that the incised valve of a child will still be adequate in later life and will not again become stenotic due to contraction of scar tissue. The ultimate value of operation on infundibular stenosis, in which a section of tissue is punched blindly out of the right ventricle, is in doubt. At present, the mortality rate of operations on individuals with tetralogy in which the direct attack was made on the right ventricle is much higher than that of the anastomotic operations. At the Children's Hospital of Philadelphia the operative death rate in all anastomotic operations has been 7 per cent; in children three years or over, 3 per cent. In reported series in which the direct attack has been tried, mortality rate has varied from 20 to 30 per cent.

In isolated stenosis of the pulmonary valve without a ventricular septal defect, the only suitable operation is valvulotomy. These individuals are not cyanotic unless a patent foramen ovale is present to permit the passage of venous blood from the right atrium into the left side of the heart.

Operations on transposition of the aorta, atrial and ventricular septal defects are still in the experimental stage.

PSYCHOLOGIC ASPECTS

A child with heart disease should not be coddled unduly, but should be expected to assume responsibility. He should be trained for an income-producing occupation. Every effort should be made to prevent the development of a cardiac neurosis. An objective attitude toward the child with avoidance of manifestations of sympathy will enable him better to accept his handicap and make whatever adjustments are necessary to lead a happy, useful life.

5636 Pine Street

THE ROLE OF THE GENERAL PRACTITIONER IN MODERN PSYCHIATRY *

Crawford N. Baganz, M.D., Lyons, N. J.

Perhaps the greatest contribution to medicine in the past decade has not been the introduction of antibiotics and of the sulfa drugs, but possibly the more widespread acceptance of the concept that psychiatry is not restricted to the psychotic patient and further that psychiatry is not a realm belonging exclusively to the psychiatrist.

About one-third of all patients who come to the office of the general practitioner have essentially emotional problems; one-third have a psychiatric plus an organic problem; and the remaining third have, more or less, a "purely organic" problem. The everyday experience of general practitioners has long confirmed the accuracy of this estimate. Obviously, the general practitioner is the pivot person in modern psychiatry.

We have outgrown the philosophy that psychiatric conditions are diagnosed by exclusion. The "exclusion" method is this: the patient has a pain in his stomach; x-ray and laboratory findings are negative; therefore the diagnosis is psychoneurosis. Currently, more and more non-psychiatrist physicians are learning the elements of modern psychiatric diagnosis and are recognizing psychiatric conditions on the basis of affirmative findings and not on the absence of symptoms of organic disease.

The general practitioner has a distinct advantage over the psychiatrist in that the patient comes to him with a complaint which is usually *not* of a "nervous" or mental disorder, but one of body dysfunction.

The general practitioner does not have to contend with the still lingering stigmata of mental illness associated (in the mind of the patient) with a visit to a psychiatrist. The general practitioner takes a careful history, does a physical examination, listens and develops the complaint factors; he is, at the same time, providing the patient with one form of modern psychotherapy. He follows this with measures planned to relieve anxiety; to reduce tension; to develop insight and to increase the feeling of self-reliance and self-confidence.

While approximately two-thirds of the patients who enter the office of the general practitioner do not have a primary psychiatric disorder, it is reasonable to expect that there are many emotional factors in the man with marginal economic status who is in bed with a broken leg; in the bride recovering from pneumonia; in the patient with chronic heart disease, neoplasm, or tuberculous infection. By treating the purely "organic" components in such cases and ignoring the emotional factors, we provide our patients with something less than complete medical care. We ignore those factors which are an essential fabric in the art of medicine.

Psychiatry and psychosomatic medicine are fields which can be properly practiced only by a trained physician; but with technics available to all physicians. Someone has defined a pediatrician as a "physician who makes a rectal examination" and a psychiatrist as a physician who listens to the patient.

If you have any doubt that emotions can produce body changes, consider your "physical" condition when you have narrowly missed a serious automobile accident. Did your pulse rate increase? Did you perspire? Did you develop a tremor? What about your respiratory rate immediately following this "narrow miss" of a serious accident? Or perhaps you have seen a cat come around the corner of a building and suddenly be confronted by his classical enemy, a dog. The cat's tail becomes bushy; his back arches; his pupils dilate; his claws protrude. If we studied this cat more closely, we would find a relative inactivity of the gastro-intestinal tract with blanching, and a relative increase in the blood flow to the organs of locomotion. Whence come these body changes? Nothing touched you, or in any

* Read before the Section on Neuropsychiatry at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 19, 1952. This paper is from the Veterans Administration Hospital at Lyons, N. J.

This article was reviewed by the Veterans Administration and is published with approval of the Chief Medical Director. The statements and conclusions of the author are the result of his own study and do not necessarily reflect the opinion of the Veterans Administration.

way harmed you in your narrow miss of the automobile accident; the cat has had no contact with the dog. The lesson is plain; such strong emotions can and do produce body changes.

Wolf[1] describes methods by which a subject was studied under various emotional stimuli. The subject had an esophageal stricture and a gastrostomy. He worked as a laboratory helper at Columbia University. One day while on the table being studied for protective mucus, color of abdominal mucosa, and extent of free acidity, he was informed that his wife had called; that the fire was out in the home; that they were out of coal; that a child was sick and they were unable to get any fuel. What happened?

His mucous membrane blanched; the acidity of the gastric secretion increased; there was an increase of motility and wiping with a cotton applicator produced local bleeding points. When told some time later that fuel had been secured for the family and everything was now all right, his gastric mucosa returned to its normal status.

In medical school we studied physiology on pithed or anesthetized animals. We now are studying physiology, at least in the research laboratories, on living human beings. We find that there is considerable difference in what we learned from the pithed frog and what actually happens in the human organism. The principal difference is that in the intact, living, human organism, emotional factors exert a strong influence on body functions not found in laboratory preparations. If the afferent impulses reaching the hypothalamus are interrupted (as in certain types of frontal lobe surgery) the individual has a decreased somatic response to emotional stimuli.

At Lyons, we have been doing research on the bitemporal electric stimulation of the hypothalamic area. We have found that by a change in the position of the electrodes we can produce a sympathetic or a parasympathetic response. From this research, we have developed procedures which are promising in the treatment of certain types of psychiatric disorders. Thus, we know, not only by inference, but by experimental evidence, the strong effect of the emotions on body functions.

So far I have talked to you about the major crises that may occur in an individual and the physiologic response to them. We are also becoming aware that nagging and worrying over a long period of time can produce symptoms similar to those found in acute emotional crises. We have also discussed emotional reactions only on a conscious level and their resulting physiologic changes. That portion of the mind called "the unconscious", probably constituting the greatest portion of our mental function, but which exists beyond awareness, exerts an even greater influence on body functions. Material that has been repressed into the unconscious portion of our mind may be a "lost memory", but it still retains its potency, its emotional effect, and its ability to produce symptoms of a psychiatric or somatic disorder. When we are able to understand the "language of symptoms" in the patient we are treating, we then recognize that these symptoms play a useful purpose. Often we must be content to modify these symptoms or replace them with less disabling ones, rather than to eliminate them entirely.

Fisher[2] has classified psychiatric disorders under three headings:

1. Emotionally determined functional disease.
2. Emotional dysfunction coupled with organic dysfunction, such as in:
 - Ulcer
 - Migraine
 - Hypertension
 - Arthritis
3. Diseases in which the psychic component is secondary to the organic component.

The role of the general practitioner in modern psychiatry involves functioning in all three of these classifications of mental disorders. The general practitioner must treat these patients in his office for many reasons, principally because of the prohibitive cost of prolonged psychiatric care by specialists; also because of the dearth of qualified psychiatrists in many areas and the total absence of such specialists in other areas.

The general practitioner knows his particular patient the best. The patient has confidence in him and the general practitioner has the ad-

1. Wolf, Stewart, and Wolff, Harold: *Human Gastric Function*. Oxford University Press. New York. 1943.
2. Fisher, Zigmond: International Journal of Teratology, 126:9876 (Dec. 1951).

vantage of an approach not exclusively psychiatric. How can a busy general practitioner give his patients the necessary time to talk? The answer is that he can't afford *not* to give them the time. He can schedule appointments with them at times when he is not otherwise occupied; they can discuss their problems with him and he can do concurrently a complete physical study. The general practitioner may well be guided by the classic statement of Strecker that, "Most patients, if allowed to talk, will diagnose their case and indicate their treatment".

Very few mentally ill patients will accept that diagnosis. They may say that they are "nervous"; that they have stomach trouble, headaches, insomnia, heart disease, or that they just "don't feel right".

It is indeed unfortunate, but it is not yet quite "decent" to be mentally ill. One of my friends on attempting to refer a patient to a psychiatrist was answered with the vehement statement, "If you think I am crazy—you're crazy!".

As a rule these individuals will seek help from a general practitioner much earlier than they will report to a psychiatrist. The modern general practitioner will be equipped and able to give guidance and understanding to their problems and will handle their therapy in most cases. He will not be equipped to treat (and, of course, he will refer promptly) the more malignant psychiatric conditions for specialized care. As in cancer or tuberculosis, the recovery rate of this group of patients depends to a great extent on how early and how adequately they are treated.

In closing, I bring to your attention a few axioms in psychiatry:

First, the symptom is usually the negative of the presenting problem; for example, a woman who lacks adequate sexual gratification may develop prudishness to protect her from unwanted stimulation.

Second, a person with a mental illness may also have a cancer, a ruptured peptic ulcer, or a cardiovascular accident.

Third, the patient who is awakened from deep and dreamless sleep with a severe pain or other organic complaint seldom has a psychogenic basis for this complaint.

When we realize that 55 per cent of all the hospital beds in the United States are occupied by patients who have a serious mental illness; when we realize that one person out of seventeen in this country is now, will be, or has been a patient in a mental hospital, then we truly realize that the future of the mentally ill, and even of psychiatry, in America will be determined by the general practitioner who first sees these patients.

Veterans Hospital

NEW OBSTETRICS—GYNECOLOGY JOURNAL

For the first time in 30 years a new monthly journal devoted to obstetrics and gynecology will be issued. Under the name *Obstetrics and Gynecology,* the periodical will release its first issue in January 1953. It is sponsored by the American Academy of Obstetrics and Gynecology. Subscription will be $12 per year. Subscriptions should be remitted to Paul B. Hoeber, Inc., at 49 East 33rd Street, New York 16, New York. Manuscripts submitted for publication should be sent to the editor of *Obstetrics and Gynecology,* Dr. R. A. Reis, at 104 South Michigan Avenue, Chicago 3, Illinois.

UNUSUAL COMPLICATION OF MILLER-ABBOTT INTUBATION *

REPORT OF SUCCESSFULLY TREATED CASE

Oscar H. Cohen, M.D., Boonton, N. J., and
Martin E. Silverstein, M.D., New York, N. Y.

Complications following the use of the Miller-Abbott tube and similar tubes have been reported from time to time. An uncommon complication is the repeated coiling of a Miller-Abbott tube through a gastro-enterostomy stoma after the tip had passed through the pylorus, duodenum and proximal jejunum. This is illustrated in the report of the following case. The rarity of published reports in the literature warrants bringing this complication to the attention of both surgeons and radiologists.[1] The Cantor tube provided a solution to this problem.

A 63 year old male was admitted to Flower and Fifth Avenue Hospitals complaining of severe diffuse abdominal pain with nausea and vomiting of forty-eight hours' duration. The onset was sudden with diffuse, crampy abdominal pain. Several hours after onset of pain, he vomited food and then bile-stained clear liquid. The pain and vomiting persisted intermittently until admission. No normal bowel movements occurred after the onset, but three low enemata had been given.

This patient had been suffering from bilateral pulmonary tuberculosis for ten years and was at the time of admission maintaining a left therapeutic pneumothorax. He had also been treated by pneumoperitoneum but had not had a refill of his pneumoperitoneum for the past seven months. Twelve years previously he had been admitted to another hospital for severe right upper quadrant pain and was told he had an ulcer. During this admission an operation was performed, the exact nature of which and the disease found was not obtainable. Thirty years previously he had an appendectomy.

He was a poorly nourished, well developed man lying quietly in bed. Blood pressure was 120/65, pulse 100 per minute and regular, respirations 24 per minute and rectal temperature was 97.6. Skin was dry and clammy. The face was sunken and "drawn" with a dry tongue. The respiratory excursions were limited. In the left chest there were hyper-resonance and distant breath sounds of bronchial character. Crackling and crepitant rales were audible in the right chest. The abdomen was distended and tender in all quadrants. Equal rebound tenderness was noted. No masses were palpable. On auscultation of the abdomen, sudden short rushes of high pitched peristaltic sounds were heard. The right external inguinal ring was patulous but no inguinal or femoral hernia masses were noted. A healed right rectus and a right McBurney's scar were noted. Rectal examination was negative.

Hemoglobin was 12.9 Grams, the red blood count 4.2 million, white blood count 14,300 with 84 per cent mature neutrophiles, 1 per cent eosinophiles, 1 per cent mononuclears, and 14 per cent lymphocytes. Urinalysis was normal. Carbon dioxide combining power was 96 volumes per cent. Urea nitrogen was 44.5 milligrams per cent, serum chlorides 460, serum sodium 340, serum potassium 10.65, total proteins 6.27, albumen 3.92 and plasma globulin 2.35 Grams per cent. Radiographs of the chest on admission showed a left pneumothorax with infiltration and fibrosis in both lung fields. Abdominal films showed distention of a number of loops of small intestine without any fluid levels. No gas was noted in the colon.

Immediately on admission, a Miller-Abbott tube was passed into the stomach and 3 cubic centimeters of mercury placed in the balloon. Drainage from the tube was acid at first and then became alkaline. Eight hours after insertion of the tube, a radiograph of the abdomen showed a slight increase in the distention of the small intestinal loops. The Miller-Abbott tube was noted extending from the esophagus into the stomach, and then through the pylorus into the duodenum and proximal jejunum. From here the tube returned to the stomach through a gastro-enterology stoma and the tip was noted to have passed through the pylorus again and was directed toward the stomal site. (Figure 1.) One hour later a radiograph of the abdomen revealed three coils of the Miller-Abbott tube circling the gastro-enterostomy stoma. (Figures 2 and 3.) The patient was then taken to the fluoroscopy room and under direct vision, the tube was slowly withdrawn until only the tip of the tube lay within the first part of the duodenum. Ten cubic centimeters of barium were then inserted into the duodenum through the tube. This was seen to pass rapidly into the distal jejunum. Each time, the tip was noted to approach the stomal site and then pass back into the stomach by what was deduced to be a ridge-like obstruction in the jejunum at the stoma. During these attempts, the mercury-filled balloon would momentarily pass into the distal jejunal loop over the obstructing ridge. Because of this, the Miller-Abbott tube was removed, and a Cantor single lumen tube was passed under fluoroscopic control. This tube has no semi-rigid tip. It is preceded by a mercury weighted rubber balloon. It was seen to "hesitate" at the

* From the Departments of Radiology and Surgery, New York Medical College, Flower and Fifth Avenue Hospitals, New York City. We are indebted to Dr. J. M. Winfield, Professor of Surgery at New York Medical College for permitting us to report his operative findings and also for his advice in the preparation of this paper.

obstructing ridge and finally to pass into the distal jejunal loop, and ultimately into the distal loops of small intestine.

After constant Wangensteen suction and supportive therapy, the distention decreased. On the fifth hospital day, the tube was clamped and recurrence of the distention occurred. On the fifteenth hospital day an exploratory laparotomy was performed. Numerous adhesions were found, and when a portion of the proximal ileum was examined, a right Richter's hernia involving the right femoral ring was noted. Upon reduction of the hernia, the intestine appeared viable and the abdomen was closed. The postoperative course was uneventful and the patient was discharged on the twenty-sixth hospital day.

The usual complications of intubation that have been reported in the literature by various authors are abscesses of the nasal septum, otitis media, sinusitis, laryngeal edema, esophageal lesions, rupture or penetration of a viscus, breakage of mercury filled balloons, inability to withdraw tubes, tracheal intubation and knotting of tubes. For many years previously, and to a lesser extent recently, the procedure of choice for the surgical treatment of peptic ulcer was a gastro-enterostomy. The potential shunting of a tube through the pylorus into the duodenum, and thence *via* the afferent loop of jejunum back through the enterostomy stoma, and around again in the same manner must be considered whenever intubation is being used



Figure 1. The Miller-Abbott tube is seen passing into the stomach, through the pylorus, returning to the stomach by way of the gastroenterostomy, into the duodenum and through the gastrojejunostomy for the second time, and the tip is shown about to return to the stomach for the third time.



Figure 2. The tube is seen completing three turns through a circle consisting of gastric antrum and pylorus, duodenum, jejunum and gastrojejunostomy.



Figure 3. Lateral view shows the three completed loops of Miller-Abbott tube.

for decompressing the bowel following gastro-enterostomy. The progress of the tip of the tube must be closely followed to avoid undue delay in accomplishing the purpose for which the tube was passed. In this situation, as in all cases where tubes are passed, frequent serial films or fluoroscopy are a necessity. A hazard may arise if the coiling of the tube through a gastro-enterostomy stoma is not recognized. Too vigorous or forcible attempts to withdraw the tube may tighten the loops of the tube and cause mechanical damage to the pylorus, duodenum, or jejunum or intervening segment of stomach. On recognition of the above reported complication, careful removal of the tube should be made under direct fluoroscopic control. As observed in this case the Cantor tube may be of greater advantage if this situation arise and if this complication is to be avoided.

SUMMARY

1. A report of an unusual complication of Miller-Abbott tube intubation is recorded.
2. The potential danger of this complication is discussed.
3. The value of the Cantor tube in passing ridge-like obstructions is suggested.

115 Church Street, Boonton, New Jersey

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VIVISECTION BROCHURE

The National Society for Medical Research announces a new publication—"38 Common Questions—38 Authoritative Answers" on the subject of animal experimentation. This is a compilation of questions commonly asked about the use of experimental animals and brief, crisp and factual answers to each of them. Included are questions about pain, the meaning of "vivisection", the ethics of animal experimentation, the animals used, and the sources of supply.

There is also a section on the legal questions concerning the use of pound animals.

About the size of a folded train schedule, the booklet is a quick reference for speakers or debaters. Physicians invited to speak before lay groups will find it of value.

A copy may be obtained gratis from the National Society for Medical Research, 208 North Wells Street, Chicago 6, Illinois.

PRIZE FOR ANTICOAGULANT PAPER

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce the subject for the prize dissertation of 1952 as "The Present Status of Anticoagulant Therapy".

For the best dissertation a prize of $200 is offered. Dissertations must be submitted by December 1, 1952, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also read his paper before the Rhode Island Medical Society at its Annual Meeting on May 7, 1953. Copy must be typewritten, double spaced, and not exceed 10,000 words. For further information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

THE MANAGEMENT OF FEMALE INFERTILITY *

Selig L. Brauer, M.D., Jersey City, N. J.

Since about 40 per cent of infertility cases involve the husband's inadequacy, it is best to wait for a semen analysis before proceeding with more than the history and physical examination on the wife. If the semen is within normal limits, the following procedure is recommended:

1. Wassermann, complete blood count, urinalysis
2. Basal metabolism
3. Tubal insufflation (Rubin test)
4. Endometrial biopsy on the tenth postmenstrual and fourth premenstrual day to determine ovarian activity
5. Postcoital (Huhner) test to determine whether cervical secretions are hostile or receptive to the spermatozoa
6. Record of basal body temperature to estimate period of ovulation
7. Hysterosalpingography, if Rubin test indicates occluded tubes

POSSIBLE CAUSES

Aside from structural and general health factors, female infertility can usually be attributed to one or more of the following:

(1) Hostility of cervical secretions, found in 30 to 37 per cent of infertility cases[1]
(2) Tubal blockage, due to tortuosity, spasm or mucous plug, found in 50 to 60 per cent[1]
(3) Absence of ovulation because of endocrinopathy, found in 10 per cent[1]

In none of the cases presented below was there any gross endocrinopathy. This paper deals principally with those cases of hostile cervical secretions, non-infectious and infectious, and tubal occlusion that responded to estrogen therapy, artificial homologous insemination, repeated insufflations, and hysterosalpingography.

ESTROGEN THERAPY

Case 1. Hostile Cervical Secretions: Non-infectious. A 26-year old woman first consulted me in May 1947. She had been married three years, but had never been pregnant. She started to menstruate at age 14. The menstrual cycle was normal.

Physical examination and bimanual examination were negative. Wassermann, complete blood count and urinalysis were negative. Basal metabolism was plus 22. Endometrial biopsies presented a proliferative and secretory endometrium, each at the proper time in the menstrual cycle. The basal body temperature chart indicated a normal curve. Rubin tests presented patency at pressure of 110. The only unsatisfactory condition found was immobile spermatozoa in repeated Huhner tests.

She was given a course of pelvic heat treatments and nutrient glucose douches for several months, with no result. Since apparently no pathologic condition was present, and the problem was the hostile effect of the non-infectious cervical secretions upon the sperm, the patient was given small doses of estrogen daily, the first twenty-one days of her menstrual cycle, in December 1947. She was advised to indulge in coitus at the time of the rise in temperature according to her basal temperature chart. This she did in December and again the following month, which was January 1948. She missed her menstrual period in February. In March 1948, Ascheim-Zondek test for pregnancy was positive. She was delivered of a normal child in October 1948.

In April 1951 she again presented herself at the office, having tried unsuccessfully for a year to become pregnant a second time. Pelvic heat treatments over a period of two months proved unsuccessful. In June 1951 estrogen was again prescribed, the patient receiving a small daily dose (0.3 milligram) for twenty-one days starting the first day of her menstrual cycle. Again she conceived and was delivered.

This patient tried twice to become pregnant and succeeded each time only after estrogen administration. Estrogen may act in two ways: (1) it may increase the glycogen content of the cervical secretions, allowing the sperm a source of energy for reaching the ovum; or (2) it may change the pH of the cervical secretions, making them more favorable to sperm reception.[1] The next case is another example of the effectiveness of estrogen therapy.

Case 2. Hostile Cervical Secretions: Non-infectious. A 25-year old woman married four years, was never pregnant. She first consulted me in October 1949. Menstruation had started at age 11, was regular, lasted six days, with no pain.

Physical and bimanual examinations were negative, as were Wassermann test, complete blood count and urinalysis. Basal metabolism was plus 10. Tubal insufflation established patency at 90. Biopsies presented proliferative and secretory phases of the endometrium at the proper time of the cycle.

* Read by invitation before the staff meeting of the Greenville (Jersey City) Hospital on February 15, 1952.

Basal body temperature chart presented a normal curve.

The Huhner test, however, was repeatedly unsatisfactory although there was no evidence of any cervical infection.

From January to April, 1950, she was given a course of pelvic heat treatments, small doses of thyroid medication, and cervical dilatations, with no result.

In September, October and November 1950, artificial insemination of husband's semen at the fertile period as determined by the patient's basal temperature, was tried also without result.

In December 1950, she was given estrogen, which she took from the first day of her menstrual cycle for twenty-one days. This treatment was repeated in January and February 1951. A month later she became pregnant. She gave birth to an eight-pound girl in November 1951.

Unlike the two cases above, the next case of infertility was due to *infected* cervical secretions hostile to the spermatozoa. Treatment of the infection did *not* produce the desired result.

Case 3. Hostile Cervical Secretions Due to Infection. A 29-year old woman first consulted me in April 1947. She had been married six years and never conceived. Menstruation started at age 12, and seemed normal. According to her history, she had had several Rubin tests in 1945, which were "satisfactory", and also had been treated previously with numerous types of injections, pills and douches.

Physical examination was negative. Bimanual examination revealed an eroded and cystic cervix. Profuse, yellow, thick leukorrhea was present. An examination of the leukorrhea showed no Trichomonas or Monilia. Papanicolau tests were negative.

Wassermann, complete blood count and urinalysis were negative. The basal metabolism was plus 15. Tubal insufflation in August indicated patency at 140 millimeters. The endometrial biopsies presented a proliferative and a secretory phase, respectively, on appropriate days of the menstrual cycle. The basal body temperature chart showed a normal curve.

Repeated Huhner tests, however, were unsatisfactory. Microscopically, spermigration was shown to be impeded by the infection.

In October 1947 the cervix was cauterized. Yet in December, a post-coital test indicated sperm-immobilizing secretions.

In January 1948, it was decided to deposit the semen beyond the area of cervical infection (by injecting it through a cannula). This was done during the fertile period, which could be inferred from the temperature chart. Just before insemination of the husband's semen, the infected cervical mucus was removed by means of suction. Then, approximately one half a minim of semen, measured in a tuberculin syringe, was injected into the uterus beyond the internal os by means of a eustachian cannula, the length of which was controlled by an acorn tip. A month later, she became pregnant and in October 1948, she was delivered of a normal male child, that lived for three days. Death was due to bilateral atelectasis.

Two months later, she returned to the office. She asked to be treated so as to conceive again. Although it was quite early for another pregnancy I felt that conception was the best treatment for her depressed mental state.

Examination was negative except that the cervix was again moderately inflamed and a Huhner test in January 1949 again showed hostile secretions.

Once again the patient was cauterized. She was given a course of penicillin injections, pelvic heat treatments, penicillin, suppositories, sulfa by mouth, sulfa intracervically, moderate cervical dilations, and estrogens by mouth. None of these measures, tried until November 1949, proved successful. The Huhner test continued to be unsatisfactory.

In January 1950 the patient again consented to artificial insemination. Husband's semen was introduced as before, at the time of ovulation indicated by the patient's chart. In October 1950 she was delivered of a normal female child.

REPEATED INSUFFLATION

The next four cases presented evidence of marked tubal spasm, a condition we are learning to differentiate from true obstruction. Two of these cases responded to repeated insufflations.

Case 4. Tubal spasm. A 26-year old woman consulted me in January 1948. She had been married four years and had not become pregnant. Menstruation started at age 13, and was normal.

Physical examination was negative. Bimanual examination presented a slightly anteflexed uterus.

Complete blood count, Wassermann and urinalysis were negative. Basal metabolism was plus 20. Endometrial biopsies presented proliferative and secretory phase, respectively, at the proper time. The Huhner test was satisfactory. The basal body temperature chart was normal.

Several attempts at tubal insufflation at 180 millimeters of mercury showed apparent occlusion, but a hysterosalpingogram done on March 23, 1948, demonstrated spastic rather than obstructed tubes. She was given a course of pelvic heat treatments and sedation. In July 1948 another tubal insufflation at pressure of 180 showed no immediate evidence of patency; but the patient reported by phone the next day that she had experienced shoulder pain a few hours after leaving the office. Infertility persisted though the tubes were patent. She refused further insufflation because of the pain she experienced (she was a hypersensitive individual). For this reason, pelvic heat and sedation were repeated, and in addition estrogen therapy was tried, but with no result.

In 1949 and 1950, she consented to an occasional insufflation, but with no success. I tried to make her understand that repeated insufflations should be done every month with the hope of maintaining tubal patency, and that this measure combined with properly timed coitus might lead to concep-

tion. In April 1951 (more than three years after her initial visit to the office) she decided to accept my recommendation. Repeated insufflations were done in April, May and June on the ninth or tenth day after the first day of the menses; that is, her ovulatory period as determined from her basal body temperature records.

In July she missed her period, and then returned to the office September 27, 1951, and was found to be pregnant.

Case 5. Tubal Spasm. A 28-year old woman had been married three years with no history of pregnancy. Her menstrual periods started at age 12, occurred every 28 days, lasted 3 days, with no discomfort.

Physical and bimanual examinations were negative. Wassermann, complete blood count and urinalysis were negative. Basal metabolism rate was plus 12. Endometrial biopsies and Huhner tests were satisfactory.

Occasional tubal insufflations during the years of 1948 to 1950 failed to show patency at a pressure of 120 to 140 millimeters. No further pressure was used because of the discomfort experienced by the patient. However, a hysterosalpingogram on March 20, 1950, demonstrated tubal spasm and not occlusion.

In addition to intermittent insufflations, she had been given a series of pelvic heat treatments, penicillin and sulfa therapy, without any satisfactory result.

A year and half after the hysterosalpingogram, the patient returned to the office, still childless. In September, October, November and December of 1951, she was insufflated and coitus was advised at the optimum fertile period in accordance with her basal temperature chart.

In December 1951 she missed her period, and in January 1951 the Ascheim-Zondek test was positive.

HYSTEROSALPINGOGRAPHY

The last two cases deal with pregnancies that followed hysterosalpingography. The procedure was undertaken for diagnosis only; it is not recommended as a general therapeutic measure.

Case 6. Questionable Occluded Tubes. A 28-year old woman consulted me on January 7, 1946. She was married six years with no history of pregnancy. Menstruation started at age 10. Periods were every 30 to 32 days, lasted 5 to 6 days, with no pain.

Physical examination was negative. Bimanual examination revealed a freely movable, moderately retroflexed uterus. Wassermann, complete blood count and urinalysis were negative. Basal metabolism was plus 12. Basal body temperature chart showed normal curve, and endometrial biopsies indicated satisfactory ovarian function. Huhner test was satisfactory.

Tubal insufflation repeatedly failed to indicate patency at a pressure of 180 millimeters of mercury.

For several months in 1946 she was given thermoflo, douches and chemotherapy, but insufflations continued to be unsatisfactory.

On May 14, 1947, hysterosalpingography, undertaken to determine point of blockage, presented a retroflexed uterus, and spasm was evident throughout the visualized tubes. The 24-hour plate showed the opaque dye on both sides of the pelvis and in the cul-de-sac.

Following this purely diagnostic procedure, the patient missed her menstrual period. In June the Ascheim-Zondek test was positive, and on February 16, 1948, she was delivered of a normal male child.

Case 7. Questionable Tubal Occlusion. A 23-year old woman consulted me on January 23, 1947. She had been married three years and had never conceived. She started to menstruate at age 13. Her periods occurred every 26 days, lasted 5 days, with no pain.

Physical and bimanual examinations were negative except for a slightly retroflexed, easily movable uterus.

Complete blood count, urinalysis and Wassermann were all normal. Endometrial biopsies were also normal, showing proliferative and secretory phases at the proper time of the cycle. Basal metabolism was plus 12. Temperature chart presented normal curve. The Huhner post-coital test was satisfactory.

Insufflations performed during the years 1948, 1949 and 1950 all showed non-patent tubes. To locate the point of occlusion, a hysterogram was done on September 22, 1950, and the medium passed into the cervix, uterus and both tubes. The uterus was seen to be retrodisplaced, and the tubes were spastic throughout their entire length. The 24-hour plate presented evidence of dye in the cul-de-sac.

Following this diagnostic measure, the patient missed her period in October. In November 1950 an Ascheim-Zondek test was positive. She was delivered of a normal female child at term.

In the last two cases, we can only speculate as to why carbon-dioxide did not, and the heavy oil medium did, succeed in relieving tubal occlusion. It is possible that the relief was only temporary, lasting long enough to permit the ovum to pass through at the proper time for insemination. However, because of certain definite contra-indications, hysterosalpingography should be used only in carefully selected cases and only for diagnosis if the Rubin test is negative.

TIMING OF TESTS

Fertility tests are timed so that they will not interfere with a possibly existing pregnancy.[4] We request the patient to defer coitus until after the Rubin test (performed on the seventh or ninth postmenstrual day), and to abstain during the month of the endometrial

biopsies, which I do on the tenth postmenstrual day (proliferative phase) and the fourth premenstrual day (secretory phase).

CONCLUSION AND SUMMARY

1. If there are no gross abnormalities in the male or female, the chances of relieving infertility are fairly good.

2. Seven cases of successful treatment of female infertility are presented.

3. Patients had tried from three to six years to become pregnant. In no case, was there gross abnormality. In every case the husband's semen was normal. Two of the patients required a second course of therapy before achieving a second pregnancy.

4. Two patients with hostile, non-infectious, cervical secretions responded to estrogen therapy. In a case of hostile cervical secretion due to cervical infection, artificial insemination of husband's semen past the area of infection, was effective. Two patients responded to repeated tubal insufflations, and two to hysterosalpingography though the latter was employed for diagnosis not for therapy. It is important to recognize the difference between tubal spasm or other temporary non-patency and structurally closed tubes.

5. The recommended procedure includes history, physical examination, basal metabolism rate, Wassermann test, complete blood count, urinalysis, basal body temperature chart, endometrial biopsies, post-coital Huhner test, Rubin test (and hysterosalpingography when indicated).

2012 Hudson Boulevard

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DEMULCENT COLLOID APPLICATIONS FOR BEDSORES

Decubitus ulcers were prevented in 25 bedridden patients prophylactically treated with a demulcent colloid paste. The paste is applied in a thick film which cushions the skin against ulcer-forming irritants. The composition and preparation of the paste are detailed by E. Raicus, M.D., in an article in *The New York Physician and American Medicine*, 38:3 (May 1952).

AWARD FOR DERMATOLOGY PAPER

The American Dermatological Association is again offering a prize of $300 for the best essay submitted for original work relative to some fundamental aspect of dermatology or syphilology.

Manuscripts typed in English with double spacing and ample margins, together with illustrations, charts, and tables, in *triplicate*, are to be submitted not later than January 1, 1953. The manuscripts should be sent to Dr. Louis A. Brunsting, 102 Second Avenue, Southwest, Rochester, Minnesota.

Competition in this prize contest is open to all medical scientists.

STATE ACTIVITIES

REGIONAL MEETING: AMERICAN COLLEGE OF PHYSICIANS

All physicians are welcome to attend the Regional Meeting of the American College of Physicians in Newark, N. J., on Wednesday, November 5. Following the scientific program, there will be a social hour and dinner at the Downtown Club (744 Broad Street) also in Newark. The scientific sessions will be at the Academy of Medicine, 91 Lincoln Park, Newark. Tickets for the social hour and dinner are $9 each and may be obtained from Dr. Asher Yaguda at 61 Lincoln Park, Newark. Admission to the scientific meeting is free. The program follows:

Wednesday, November 5—Academy of Medicine, Newark

2:00 p.m.—Pheochromocytomas.
Marvin Becker, M.D., Newark

2:30 p.m.—"Notions on Neurotics".
Hilton S. Read, M.D., Atlantic City

3:00 p.m.—"New Viewpoints from Studies of the Blood".
Sylvan Moolten, M.D., New Brunswick

3:30 p.m.—The Treatment of Hypertension.
William A. Jeffers, M.D., Philadelphia

4:15 p.m.—Isoniazid Derivatives in the Treatment of Tuberculosis.
I. J. Selikoff, M.D., Paterson, and Paul K. Bornstein, M.D., Asbury Park

4:45 p.m.—Treatment of Thyroid Disease.
T. H. McGavack, M.D., New York City

5:15 p.m.—Film of the Cleveland Session, American College of Physicians.

6:00 p.m.—Social Hour at the Downtown Club, 744 Broad St., Newark.

7:00 p.m.—Dinner (informal) at the Downtown Club.

8:00 p.m.—Guest Speaker: T. Grier Miller, M.D., President, American College of Physicians.

PSYCHIATRY AND NEUROLOGY FOR GENERAL PRACTITIONERS

The Veterans Administration announces an intensive, full-time, four-months course in psychiatry and neurology, fashioned to meet the needs of physicians without previous training in those specialties. Physicians may request this training by applying for a position in one of a number of VA hospitals. Doctors participating in this program will receive the regular full-time salary of the VA physician: from $5500 to $11,800 per year, depending on previous experience and training in medical practice. Courses will be given at VA hospitals in Coatesville, Penna.; Chicago, Illinois, and Palo Alto, California. However, the applicant will first be assigned for duty to another VA hospital and then detailed to the training center for the four month period. For further information, write to Manager, Veterans Administration Hospital, Lyons, New Jersey.

THYROID AWARD

The American Goiter Association offers the $300 Van Meter Prize for the best essay on problems related to the thyroid gland.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be typewritten double spaced and sent to Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than February 15, 1953.

PENFIELD TO LECTURE IN NEWARK

Dr. Wilder Penfield will give the Beling Memorial lecture on Friday evening, November 14, 1952, at the Academy of Medicine, in Newark. The subject is not yet announced. The meeting will be held in conjunction with the Academy of Medicine graduate week, and is sponsored by the New Jersey Neuropsychiatric Association.

NATIONAL GASTRO-ENTEROLOGICAL ASSOCIATION

The National Gastro-enterological Association will hold its Annual Convention and Scientific Sessions at the Hotel Statler in New York City, on October 20, 21 and 22, 1952.

Included in the program will be a symposium on liver diseases. Another feature of this session will be a symposium for the general practitioner. There will also be a symposium on bleeding esophageal varices and the problems of portal hypertension. Another interesting panel discussion will be on gastro-intestinal x-ray methods.

Immediately following the convention, on October 23, 24 and 25, the Association will conduct its Annual Course in Postgraduate Gastro-enterology at the Hotel Statler in New York. This course will be under the personal direction of Drs. O. H. Wangensteen of Minneapolis, Minn., and I. Snapper, New York, N. Y.

Further information concerning the program and details of the course may be obtained from the National Gastro-enterological Association, 1819 Broadway, New York 23, N. Y.

OBITUARIES

DR. SAMUEL ALEXANDER*

Past-president of The Medical Society of New Jersey, Dr. Samuel Alexander died at his desk in the conference room of Bergen County's Board of Freeholders on September 3, 1952. He was—and had been for 24 years—a member of the Board of Chosen Freeholders, and several times, Director of that Board. Born in New York in 1888, he was graduated from the Long Island College Hospital in 1910. The following year he came to New Jersey, setting up an office in rural Park Ridge in Bergen County. There he practiced for 41 years. Although his practice was an active and busy one, he found time for a rich variety of community activities. He was a Councilman in Park Ridge, then for six years was Mayor of the borough. He was elected to the Bergen County Board of Freeholders in 1928, and re-elected without interruption since that time. He was president of the Park Ridge Bank, president of the County Health and Sanitary Association, president of the Bergen County Medical Society. His career in organized medicine carried him, step by step, up the ladder, and in 1945, he became President of The Medical Society of New Jersey.

DR. MAURICE CHESLER

Dr. Maurice Chesler of Salem, died suddenly on September 8, 1952, at the age of 59.

Dr. Chesler, who had practiced in Salem for 17 years, received his medical degree at the University of Pennsylvania in 1917. He took graduate studies in children's diseases at the Universities of Berlin and Vienna.

Dr. Chesler was a former president of the Salem County Medical Society, and was an active member of the American Legion.

DR. CHARLES L. O'NEILL, SR.

Dr. Charles L. O'Neill, Sr., of Newark, died on August 26, 1952.

Dr. O'Neill was born in Newark in 1883. He was graduated from Cornell Medical College in 1908 and interned at St. Michael's Hospital, where he was attending physician for many years. He was honored in 1948 for his long service at St. Michael's and was designated Visiting Staff Physician Emeritus. He was a member of the Society of Surgeons of New Jersey and the Physicians' Club of Essex County.

DR. JAMES H. ROSECRANS

Dr. James H. Rosecrans, dean of Hudson County medical profession, died on September 5, 1952.

Born in Columbus, Wisconsin, in 1857, Dr. Rosecrans was graduated from Bellevue Medical College in 1883. After interning at Randalls Island, he moved to Hoboken, where he practiced for more than 60 years. He was chairman of the Hudson County Mosquito Extermination Commission in 1927, and was a member until a few years ago. Dr. Rosecrans was active in a number of civic and social groups, and was an Emeritus Member of the Hudson County Medical Society and of The Medical Society of New Jersey.

DR. CHARLES H. SCRIBNER

Dr. Charles H. Scribner of Preakness, who practiced in Paterson for more than 60 years, died on August 14 at the age of 90.

Dr. Scribner was born in Rosendale, Wisconsin, and received his medical degree in 1890 from Columbia University College of Physicians and Surgeons. He interned at St. Joseph Hospital in Paterson and for many years was on the staff of that hospital. He was an Emeritus Member of the Passaic County Medical Society and of The Medical Society of New Jersey.

* For editorial comment on the death of Dr. Alexander, see page 416 this JOURNAL.

Medical-Surgical Plan of New Jersey

"New Jersey's Blue Shield Plan"

WHY EVERY DOCTOR SHOULD BE A PARTICIPATING PHYSICIAN

Medical-Surgical Plan is the medical profession's own constructive solution to the problem of making available prepaid medical service to people of low and medium incomes. It was organized through the initiative of The Medical Society of New Jersey.

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Your Participation in Medical-Surgical Plan is tangible evidence to your Patients and to all the more than 800,000 subscribing members of the Plan, that you are supporting this national effort of your profession to meet the public need for prepaid medical service through voluntary methods.

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Medical-Surgical Plan—by virtue of your Participation—*is the only medical insurance plan* in New Jersey that makes available *service* benefits to the patient, and direct *cash* benefits to the physician.

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The average payment per case made by Medical-Surgical Plan in 1951 exceeded that of any other Blue Shield Plan in the United States. Many of these payments were made on behalf of subscribers who—except for Medical-Surgical Plan—would have been attended by their physicians with little or no compensation to the physician.

●

Medical-Surgical Plan exists only so long as a majority of the practicing physicians of New Jersey support it as Participating Physicians. In order for Medical-Surgical Plan to continue to expand and to arrive at its maximum enrollment, it is desirable that all eligible physicians in the State Participate.

●

Medical-Surgical Plan is advised by the organized medical profession in New Jersey. More than half its Trustees must be members of The Medical Society of New Jersey, and every Trustee must be approved by the Society before election to the Board.

●

Medical-Surgical Plan has been guided and sustained by the devoted and unremunerated services of many leading members of the profession. It is supported by 5200 New Jersey physicians who have voluntarily signed an agreement with the Plan as Participating Physicians. *Are you doing your share?*

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel on September 12, 1952, with Dr. Robison D. Harley, President, presiding.

Dr. Michael Scott, Professor of Neurosurgery, Temple University Medical School, spoke on "Head Injuries".

Dr. Holland announced that the Public Relations Committee is preparing a training course for medical secretaries in conjunction with the local school system. He also reported that the Emergency Medical Service Plan had handled over 500 emergency calls during the past summer season.

Dr. Allman read resolutions on the death of Dr. Myrtile Frank.

Dr. Gleason reported that only 17 members had signified their interest in joining the Medical-Surgical Plan of New Jersey, whereas the plan requires a total of 51 per cent of our membership, or 76 doctors, in order to accept us as a group.

Dr. Frank B. Doggett, Jr., has returned home from a tour of duty in Korea and Japan, and will be placed again on our active membership list.

Dr. Werner Vandenberg is planning to leave for an extended period of specialty training, but has requested that he be maintained as a member of our Society.

BERGEN COUNTY

John E. McWhorter, M.D., Reporter

The regular monthly meeting of the *Bergen County Medical Society* was held on September 9, 1952, at Bergen Pines Hospital, Paramus.

The President, Dr. G. Barton Barlow, read the names of the physicians elected to membership in June and those present stood and received the applause of the membership-at-large.

The Secretary, Dr. John E. McWhorter, read a resolution on the death of one of the members, Dr. Samuel Alexander. The resolution was unanimously adopted.

Dr. Barlow then introduced Mr. Richard Nevin, Executive Officer of the State Society, who spoke briefly on the Society's objectives for the coming year. He also spoke of the improvement in public relations in Bergen County and of the work of Mr. Norris, public relations counsel, in this connection.

Mr. Nevin introduced Dr. Vincent Butler, Second Vice-President of the State Society, and Chairman of the Medical-Dental School Committee. Dr. Butler gave a short history of the work that has been done so far to obtain a medical-dental school for New Jersey. Dr. Butler emphasized that the school will be a health center for the state, with many public health services and facilities, as well as being a school to prepare students to enter medicine and dentistry. Dr. Butler asked for the cooperation of each physician in promoting this idea.

The meeting was then turned over to Dr. Lee Solworth, Chairman of the Scientific Committee, who introduced the speaker of the evening, Dr. George Pack. Dr. Pack spoke on *The Extension of Radical Surgery in the Treatment of Cancer* and illustrated his talk with movies.

BOOK REVIEWS

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of Northern New Jersey

Childhood Experience and Personal Destiny. By William V. Silverberg, M.D. Pp. 289. New York, Springer Publishing Co., Inc., 1952. ($4.50)

The "pin-up girl" of present-day medicine is psychiatry. In turn, we might say that the "pin-up girl" of psychiatry is child psychiatry. This is as it should be. For psychiatry, like other branches of medicine before it, has finally reached the point of devoting considerable interest and energy to the prevention of illness. This has led to increasingly detailed studies of the relationships between the early development and rearing of a child and his subsequent emotional health—in short, between childhood experience and personal destiny.

Silverberg presents the thesis that "—mental illness originates in adaptations made to traumatic experiences in early life, and that, in its details, the illness bears the impress of those experiences and the child's reactions to them". This is a truism, but in developing it, the author does not serve up a re-heated dish of old food. He begins with a critical discussion of Freud's instinct theories on the basis that the ego as conceived by Freud does not have a source of energy of its own. Rather it is required to borrow either from the erotic or aggressive drives. Silverberg asks, "By what agency does the ego do this?" He then postulates a different kind of energy which has as its chief goal the "survival of the total organism" and which operates through the medium of "effective aggression".

The latter term is an operational concept accounting for the ego's efforts in the direction of *achievement* as well as of *defense*. This concept of achievement, Silverberg bases on the young child's "obvious tendency to *do* something, a something which is neither defense against nor avoidance of danger, but merely wish-fulfilling".

Having given the ego the chief goal of survival, the author distinguishes between somatic survival and psychic survival. Here he lays the groundwork for the discussion which follows of those kinds of experience within our American culture which favor growth or diminution of ego-strength, or, in other words, which tend toward emotional health or illness. For each area he investigates the child's typical adaptations to the difficult situations encountered. These adaptations he classsifies as "heroic" (rebellious) and "unheroic" (submissive). They represent the child's constant efforts to obtain parental love and approval while at the same time trying to reach pleasurable goals.

Since adaptations, whether normal or pathologic, are acquired as the result of experiences of living, it follows that experiences in the therapeutic situation provide opportunities for developing new and better adaptations, and, therefore, better mental health. This is the hope held out by Silverberg as he brings his book to a close with a section on treatment.

Written lucidly, this well-thought out work provides an unusually satisfying and enriching experience. It is recommended to every psychiatrist, psychologist and caseworker.

Arnold M. Kallen, M.D.

Revitalizing a Nation. By Douglas MacArthur. Garden City, N. Y. 1952 (Garden City Books for the Heritage Foundation, Inc., Chicago.) Pp. 121. Fibre-bound. ($1.00)

At first it seemed odd that a medical journal should be asked to review this little book. This is a compilation of the opinions and policies of General of the Army MacArthur as reflected in his public pronouncements. It seems far removed from the textbooks of obstetrics and ophthalmology which normally come to us for review. But on second thought, the assignment is found to be not inappropriate. Medicine is not practiced in a vacuum and our opportunity to practice it as free men is manifestly dependent on the political climate in which we work. There can be no free, honest or effective practice where the State decides which scientific theory is to be followed.

The book has an introduction by Norman Vincent Peale, D.D. It was edited by John M. Pratt. It includes 24 pages of photographs which constitute visual evidence of the affection with which the American people hold the General. Although there is concrete discussion of our military problems and their political overtones, there is also a flavor of spirituality about the text which will be gratifying to many. The problem of establishing peace is seen as "basically theological, involving a spiritual recrudescence". The military situation in Korea and our commitments in Europe are soberly analyzed. The basis of General MacArthur's astonishingly successful proconsulship in Japan is illuminated. He obviously had the knack of filling the spiritual vacuum left by Japan's total defeat. Like all who have seen much of war, the General wants a world at peace. "Could I have but a line a century hence" he writes "crediting a contribution to the advance of peace, I would gladly yield every honor which has been accorded by war."

Henry A. Davidson, M.D.

Antibiotic Therapy. Henry Welch, Ph.D., and Charles N. Lewis, M.D. Pp. 562. Washington, D. C., Arundel Press, Inc., 1951. ($10.00)

Sometime during the relentless progress of medicine it is necessary to stop and look over the ground that has been covered, to assimilate and correlate the knowledge that has been gained in a particular field. Henry Welch and Charles N. Lewis of the United States Government Food and Drug Administration, in "Antibiotic Therapy", have compiled just such a review in the field of antibiotics. However, anyone attempting such a survey runs the risk of having medicine hurtle on past, so that by the time the data have been sorted, much of it has become out of date. Fortunately, the authors have done an excellent job of reviewing what has been accomplished in the field of antibiotics from the clinical point of view. This work does not suffer from obsolescence.

The book is divided into two main sections. The first describes each of the antibiotics from the point of view of development, pharmacology, methods of use, and dosage. Included are interesting biographic sketches and photographs of some of the pioneers in the field. The second part of the book is concerned with the comparative clinical uses of the antibiotics. Here disease entities are discussed in relationship to the antibiotics concerned in their therapy. Excellent references to the literature are given in both sections.

The busy practitioner will find quick reference sections to answer questions about the use of the drugs for specific diseases. Although the text is mainly for such clinical reference, the researcher, too, will find the volume useful because of the very thorough review of the literature.

The book is recommended to anyone interested in the scientific use of the antibiotics.

Albert M. Silver, M.D.

The Origin of Life and the Evolution of Living Things. By Olan R. Hyndman, M.D., Philosophical Library, New York, 1952. 648 pages. ($8.75)

The author of this book is a neuro-surgeon, who states in his preface that "It would appear that all the significant discoveries in science were by accident. This is, at most only partly true. Since my thesis on organic evolution is a consolidated argument against accident and fortuity, the mood compels me to hold the same view toward any evolution. No discovery was ever made by one who was not looking for something. That he may chance to flush unexpected game makes neither him nor the game an accident."

The author attempts to "explain the origin and evolution of living things on a physico-chemical basis and as expressions of the operation of natural law". He discusses the hypothesis of the origin of living matter—"On the Origin and Evolution of the Germ Integer, and the Origin and Evolution of the Cell", "Reproduction—Asexual and Sexual", "Organic Evolution", "On the Origin of the

Species", "Analysis of the Parasites and Saprophytes with the Instrument of the Germ Integer Concept" and "On Senescence and Death of the Individual".

In his "conclusion" the philosopher-neuro-surgeon-author, in good readable English tries to explain his theories, discusses "determinism and teleology" and the rather difficult-to-grasp hypothesis he sets forth.

This work will have only a very limited interest for the busy general or specialized practitioner of medicine. Perhaps, some geneteeists, psychologists and oncologists may find this book of interest.

HYMAN I. GOLDSTEIN, M.D.

New and Nonofficial Remedies. Edited by Council on Pharmacy and Chemistry of the American Medical Association. Pp. 838. Philadelphia, Lippincott, 1952. ($13.00)

In order to keep pace with changes in therapeutics, the American Medical Association annually issues this well-known volume. The book includes a list of accepted products grouped under such functional headings as "Agents used in Allergy", "Diagnostic Aids", "Vitamins" and the like. There is also a long section on tests and standards and an alphabetically arranged index of unaccepted products, which cites the monographs of the *A.M.A. Journal* or elsewhere which describe the product and indicate why it is unacceptable.

To avoid making the volume too large, the monographs which appeared in the last three issues are not here repeated. However, the drugs accepted since 1949 are listed alphabetically in the index with a cross-reference to the volume in which the full monograph appears.

New and Nonofficial Remedies is so well-known and so obviously useful that it needs no special recommendation here. It is or should be a readily available volume on the desk of each medical practitioner.

HERBERT BOEHM, M.D.

Ambulatory Proctology. By Alfred J. Cantor. M.D. 2d ed. Pp. 563. New York, Paul B. Hoeber, Inc., 1952. ($10.00)

This simple, yet complete encyclopedia, is offered for consultation and guidance for general practitioners. The volume is well written, well printed, and nicely indexed on good paper. It is up to date, timely, and covers the subject indicated fully and well.

Cantor has a gift for lucid description and in most instances goes into detail adequately for the purpose of this volume. He presents his material with gusto and charm and maintains the readers' interest in the subject under discussion. His forte is simplification and illumination. He writes, in many instances, with such skill that he might encourage the ingenuc to proceed blithely "where angels fear to tread". Therein lies, possibly, an important objection to this book. The author is not seriously recommending that the general practitioner perform in his office much of the surgery described here. He describes very well a wide range of proctologic procedures which can be assumed by the trained and experienced proctologist in a fully-equipped and smooth-running office which closely if not completely simulates hospital conditions. Such a proctologist undertakes these procedures as definite and calculated risks.

The section on pediatric proctology is inadequate and antiquated in view of recent developments in this line. The resume, in particular, of Hirschprung's disease is definitely dated. The syndrome of pruritus ani is one of the commonest and most trying problems which reaches the general practitioner; coverage of this complex is too brief. Likewise, the coverage of chronic ulcerative colitis revealed inaccuracies, brevity, and misleading references about the latest concepts of surgical treatment.

RICHARD A. HOPPING, M.D.

A History of the American Dermatological Association in Commemoration of Its Seventy-fifth Anniversary 1876-1951. By Paul E. Bechet, M.D. Foreword by Henry E. Michelson, M.D. Froben Press, Inc., New York, N. Y. 1952.

The oldest dermatologic society in the world was founded in New York in 1869. The specialty was then emerging from its infancy with astonishing speed. Graduate students such as George Henry Fox and Henry G. Piffard brought back to the American metropolis the innovations of such masters of dermatology as Hebra of Vienna, Bazin of Paris and Tilbury Fox of London. The formation of specialty societies became necessary to afford an opportunity to exhibit unusual cases and discuss newer theories. Six years after the founding of the New York Dermatological Society (and under the stimulus of six of its members) the American Dermatological Society came into being. Since then it has played a vital part in the development of the specialty in this country, and the contributions of its members have shed lustre on American medicine throughout the world. Such men as Duhring and Schamberg of Philadelphia, Fox and Fordyce of New York, Gilchrist of Baltimore and Bowen of Boston, to name but a few of the older group, have secured lasting fame by describing disease entities to which their names have become attached. Since 1929 the Society has had the good fortune to have on its roster a man who combines a pleasing literary style with a scholarly interest in books, the life of Napoleon and the history of American dermatology. In this latter field he has ploughed more thoroughly than any other individual, basing his numerous writings on original sources acquired in large part directly from early members of the A.D.A. or their descendants.

The present work, summing up a lifetime of interest and devotion, is a genuine labor of love. Since the author knew intimately almost all the founders and early members he was able to study their personalities with Boswellian care not only at the annual meetings, but also through reminiscences imparted directly or through the medium of a voluminous correspondence. The result is an original piece of Americana, blessedly lacking in that sense of impersonality which makes most works of this type as tedious as a college year

book. Since Dr. Bechet on several occasions discussed with this reviewer the difficulties involved in getting this volume to press in time for the 75th anniversary while in the midst of an active practice it is a pleasure to greet the appearance of this study, distinguished alike by its content and format.

Morris H. Saffron, M.D.

The Treatment of Injuries to the Nervous System. By Donald Munro, M.D. Pp. 284 with 47 figures. Philadelphia, W. B. Saunders Company, 1952. ($7.50)

Injuries to the brain and central nervous system are usually seen first by the general surgeon or the general practitioner. This book is written primarily for them. As the author points out in his preface, the therapy of injuries to the nervous system is new and is still in a state of flux. While such information is procurable from the medical journals, it has not yet been made available in book form. This compact and well-written volume undertakes to do just that and it does so successfully. With remarkable attention to detail, the book covers each of the numerous minor points which go to make up the total care of the traumatized patient. The point of view expressed is completely modern and most of the references date from 1944 onward. Since World War II a good deal has been learned about the treatment of head injuries and, in particular, the treatment of spinal cord injuries. It is now well known that effective early treatment plus appropriate rehabilitation technics can materially reduce disability. Munro throughout the book stresses recent advances in attitude and technic and sets up a standard for the general surgeon and the general practitioner to follow.

There is a detailed outline of contents and a very complete index so that specific subjects are easily made available. One can refer to this volume with specific problems in mind and readily locate chapters and paragraphs dealing with specific subjects. As one would expect in a volume of this size, there is little "theory". For the most part, the book deals with specific recommendations, procedures and practices. This work fulfills a useful role and should be available to every surgeon and general practitioner treating traumatic injuries of the nervous system.

Lewis H. Loeser, M.D.

Heart Disease. By Paul D. White, M.D. 4th ed. Pp. 1015. New York, Macmillan Company, 1951. ($12.00)

Since the first edition of this book appeared, it has become a classic both as a textbook for the medical student and as a reference source for the general practitioner, internist and cardiologist.

In the past six years there has been sufficient research in the cardiovascular diseases to necessitate this revision. With the increase in life span and the increasing numbers of people suffering from heart diseases, research in technics dealing with prevention, diagnosis and treatment is being carried out on a national scale. The editors have extensively revised the chapter of electrocardiography to bring it up to date. A brief account of electrofluorokymography has been added as well as a discussion of ballistocardiography. The most important section of the book deals with the prevalence, causes and types of heart disease. The chapter on congenital defects has been brought up to date.

There is an extensive bibliography at the end of each chapter.

This authoritative book is recommended to the general practitioner, to the internist and to the cardiologist, and should be part of every doctor's library.

Jerome G. Kaufman, M.D.

Paracelsus. Magic Into Science. By Henry M. Pachter. Pp. 360. Illustrated. New York, Henry Schuman, 1951. ($4.00)

This is an interestingly presented life history with adventures, prophecies, beliefs, disagreements, and experiences of Philippus Theophrastus Aureolus Bombastus ab Hohenheim commonly called Paracelsus, doctor of medicine, professor of theology, and expert in the alchemical art. Paracelsus "cured" patients whom ordinary doctors had abandoned for doomed, and he knew wonderful elixirs that restore youth to the old!

Paracelsus (1493-1541) was indeed the controversial character of the Renaissance Age. However, "fakir" or scientist, he played a very important role in the history of medicine. He was born in Switzerland, the son of a physician. He studied at Basle, and Ferrara, Italy, and visited Germany. He served as town physician and as professor at the University in Basle. He died at Salzburg at age 48, probably the result of cancer.

The author has given us some historical facts, and an interesting and easily readable story of a prominent character of the early decades of the sixteenth century.

Hyman I. Goldstein, M.D.

Correlative Cardiology. By Carl F. Shaffer, M.D. Pp. 525. W. B. Saunders Company, Philadelphia, 1952. ($9.50)

This compendium for the students of cardiology does not sacrifice clarity while maintaining thoroughness and brevity. The authors have condensed a great deal of information into a reasonable number of pages by use of the outline form. The first section is devoted to anatomy, physiology, special diagnostic procedures, and physical diagnosis. One is impressed by the numerous schematic illustrations which help integrate the discussions in question. The section on electrocardiography is complete, up-to-date and easy to follow.

In the remaining chapters, which deal with specific cardiac disorders and their treatment, the book truly justifies its title. Laboratory data and special diagnostic measures are correlated with the clinical findings and emphasis is placed on cardiac function as the key to correct diagnosis and successful management. The book will be a useful reference and a reliable review for students of heart disease.

Sol Parent, M.D.

TUBERCULOSIS
ABSTRACTS

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Vol. XXV October, 1952 No. 10

INTERNATIONAL HEALTH

By Frank G. Boudreau, M.D., American Journal of Public Health, December, 1951.

Progress in the speed of travel and communication emphasizes the lesson of one world, but two widely contrasting worlds continue to exist side by side: the world of good health, long life, and high standards of living, and the other world of disease, hunger, and premature death. We who live in the healthy and prosperous world are outnumbered about three to one by those who do not happen to be so fortunate, and the disparity is growing. It would be folly to imagine that two such different worlds can continue to exist side by side in peace, for you cannot expect the peoples of the other world to be content to remain forever in the misery to which they have been condemned by the accident of being born in the wrong country.

Two courses are open to us. We may decide to isolate ourselves from the other world and arm to the teeth to defend our homes and our goods. We know by dearly bought experience that isolation is no longer possible, while history teaches that the armaments race leads inevitably to widespread war and that world wars reduce victors and vanquished alike to misery and ruin. Or we can resolve to assist the people of the other world to lift themselves out of their misery by helping them to develop their human and material resources.

Public opinion in our world of plenty is slowly forming in favor of the second course which is advised by economists as well as by conscience. The speed at which our world is being transformed requires us to act rapidly and with conviction. But our whole inclination is to temporize, to try to gain a little time, to put off the great decision.

This, then, is the framework in which we view our stake in world health; a world rushing faster and faster to its destiny, its people crowded closer and closer together but torn by hatred and haunted by fear, equipped with the most deadly weapons ever invented, and unable fully to understand or to influence human behavior.

The definition of the word "stake" is that found in Webster: anything material or nonmaterial which we are in danger of losing. What, then, is our stake in world health, what are we in danger of losing if our support of the World Health Organization continues to be unimaginative and half-hearted?

We may lose the chance to rid the world of those ancient scourges which have afflicted mankind through the ages: malaria, plague, cholera, and yellow and typhus fevers. We may lose the chance to rid the world of the suffering and death caused by the worst manifestations of the major deficiency diseases: beriberi, scurvy, rickets, pellagra, and others less familiar to us. These diseases still number their victims in millions, yet are under control in the more advanced countries. We shall lose our chance to take part in the building up of a great stock pile of knowledge and experience in the maintenance of health and the prevention and treatment of disease. No nation has a monopoly of this knowledge and experience. We owe to German science the idea of synthetic drugs; penicillin came to us from Britain, insulin from Canada, DDT from Switzerland, the electrocardiograph from The Netherlands. Public health and modern medicine have been built up

by the contributions of many workers in many lands. The stock pile is growing. Every day it becomes more valuable. Every day new useful knowledge is pouring out of research laboratories in many countries. Its use is often delayed by the barriers of language and man-made frontiers of prejudice and insularity. Breaking down these barriers is a task for which WHO is exceptionally qualified.

We may lose the opportunity to build up a world-wide united front for good health and disease control. In warfare and in disease control, no gaps must be found in the front facing the enemy, every sector must be held by first-class troops armed with the best weapons that science can provide. These armies are the health services and medical and health institutions in the different countries. Some are weak, undermanned, underofficered, and underequipped. In some countries they are virtually nonexistent.

WHO is engaged in building up this army of health. The least developed countries have the greatest need for more qualified physicians, more trained health officers, more nurses, more sanitary engineers. These countries also stand in greatest need of hospitals, medical and public health and nursing schools, research institutes, health centers and many others. It will take time to provide them, but in a cooperative world a start may be made at once. Every increase in the number of trained health workers will bring added efficiency in the fight against disease; every moment that we hesitate to support world health means unnecessary suffering and death to men, women, and children in many countries.

We may lose the chance to build peace into the minds of men. Our present age is characterized by aggressiveness and competition. These qualities may have been necessary for survival when food production could not keep pace with population growth, but they are anomalies in the industrial and scientific world of today. Our problem is to make the challenge of peace appeal to men more strongly than the excitement of war. Progress in the development of new lethal weapons of war far exceeds the rate of advance in our understanding and control of human behavior. We do not allow a child of five to take the throttle of a great locomotive but minds just as immature are likely to be found in control of far more lethal forces.

The challenge of the times is to sublimate man's aggressiveness into vigorous cooperative action toward building a world society in which opportunities for health, long life, rising standards of living, and freedom will be open to men, women, and children of every race, creed or country. Our present aggressiveness and competitive spirit must give way to compassion, sympathy, and cooperation. WHO's present programs for mental health need to be developed and expanded until they cover the earth. Combined with education they may turn out to be keys to the solution of our most pressing problem—how to build peace into the minds and hearts of men, how to adapt man's behavior to the conditions and complications of the new world in which he lives.

The World Health Organization is peculiarly fitted to become the spearhead of a world revolution which will have as its aim not the destruction of present civilization, but the organization of a peaceful world, not the leveling down of all countries to lower standards of living, but the raising up of the poorer countries to the standards of the most healthy and prosperous. This is within our grasp; we have the ability and the means to do it; only the will falters, only the imagination fails.

The preamble to the Charter of the United Nations begins with the words, "We, the peoples of the United Nations. . . ." These words were used to emphasize that the new world must be built by peoples as well as by governments. The initiative of the National Health Council in setting up a United States Citizens' Committee will give the people of our country an opportunity to work for world health as the spearhead of a movement for the organization of world peace. It will give professional health workers the privilege of taking the lead in meeting the most exciting and momentous challenge mankind has ever faced.

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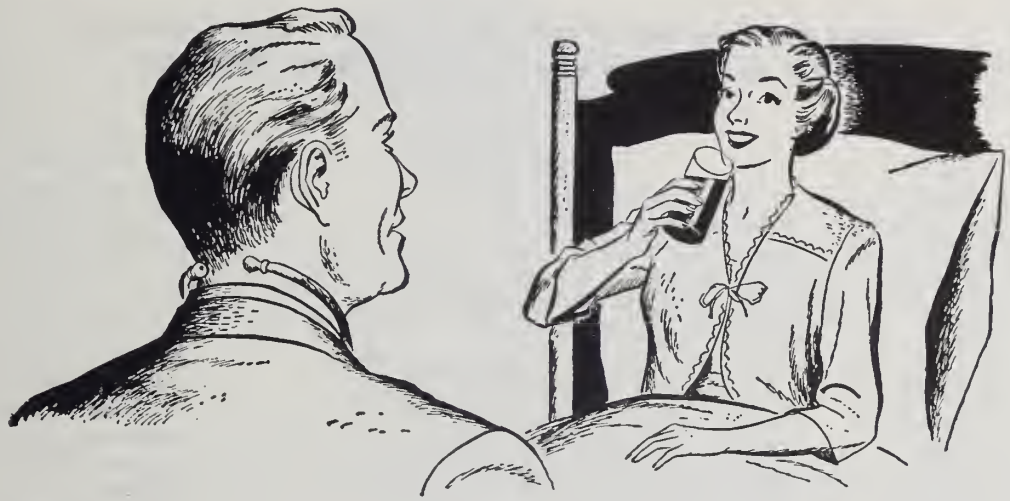
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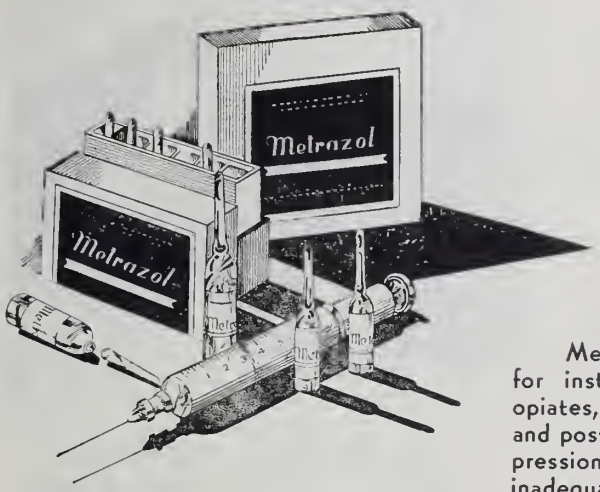
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Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

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31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
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*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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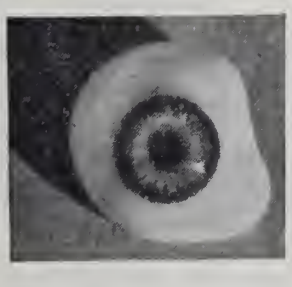
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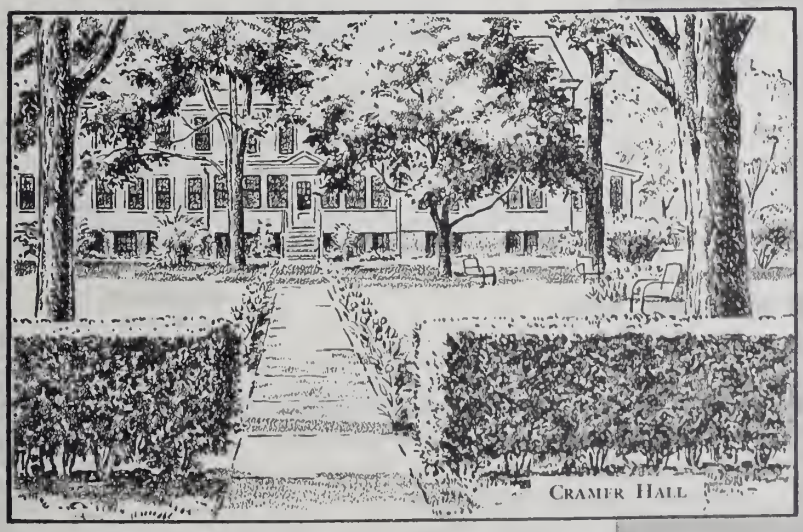
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1. Michael, N.: Ohio State M. J. *48*:42, 1952.
2. Carter, S., in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, p. 610.
3. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 1379.
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5. Christian, H. A.. The Principles and Practice of Medicine, ed. 16, New York, D. Appleton-Century Company, 1947, p. 1370.

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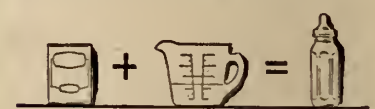
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*Frost, L. H., and Jackson, R. L.: J. Pediat., 39:585-592 (Nov.) 1951

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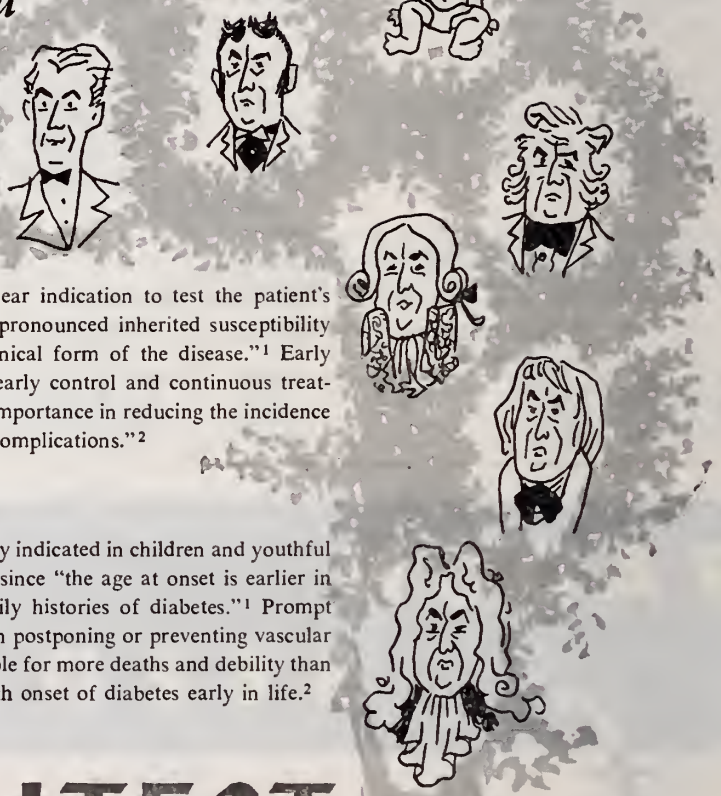
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2. Wilson, J. L.; Root, H. F., and Marble, A.: J.A.M.A. *147*:1526 (Dec. 15) 1951.

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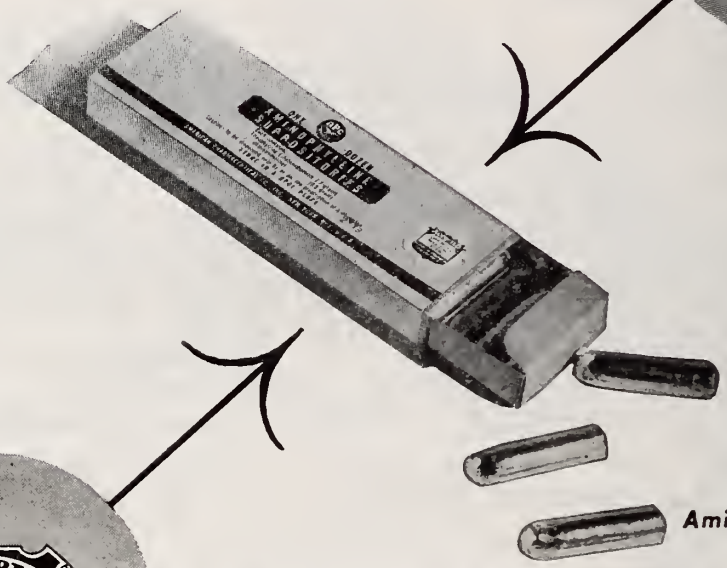
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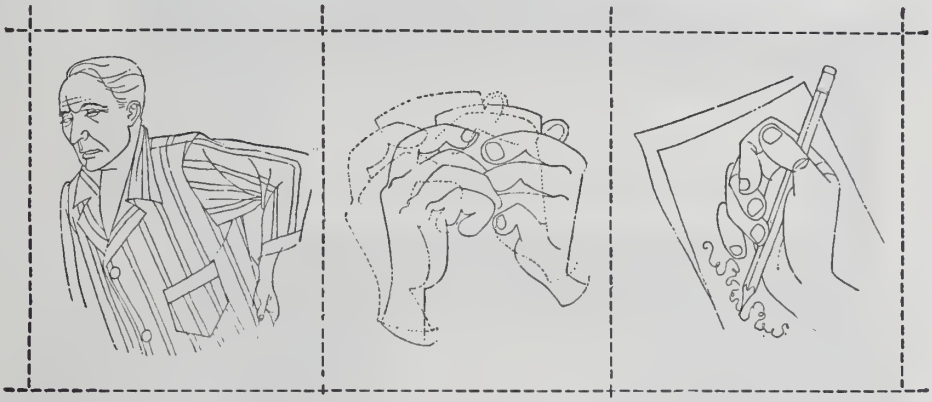
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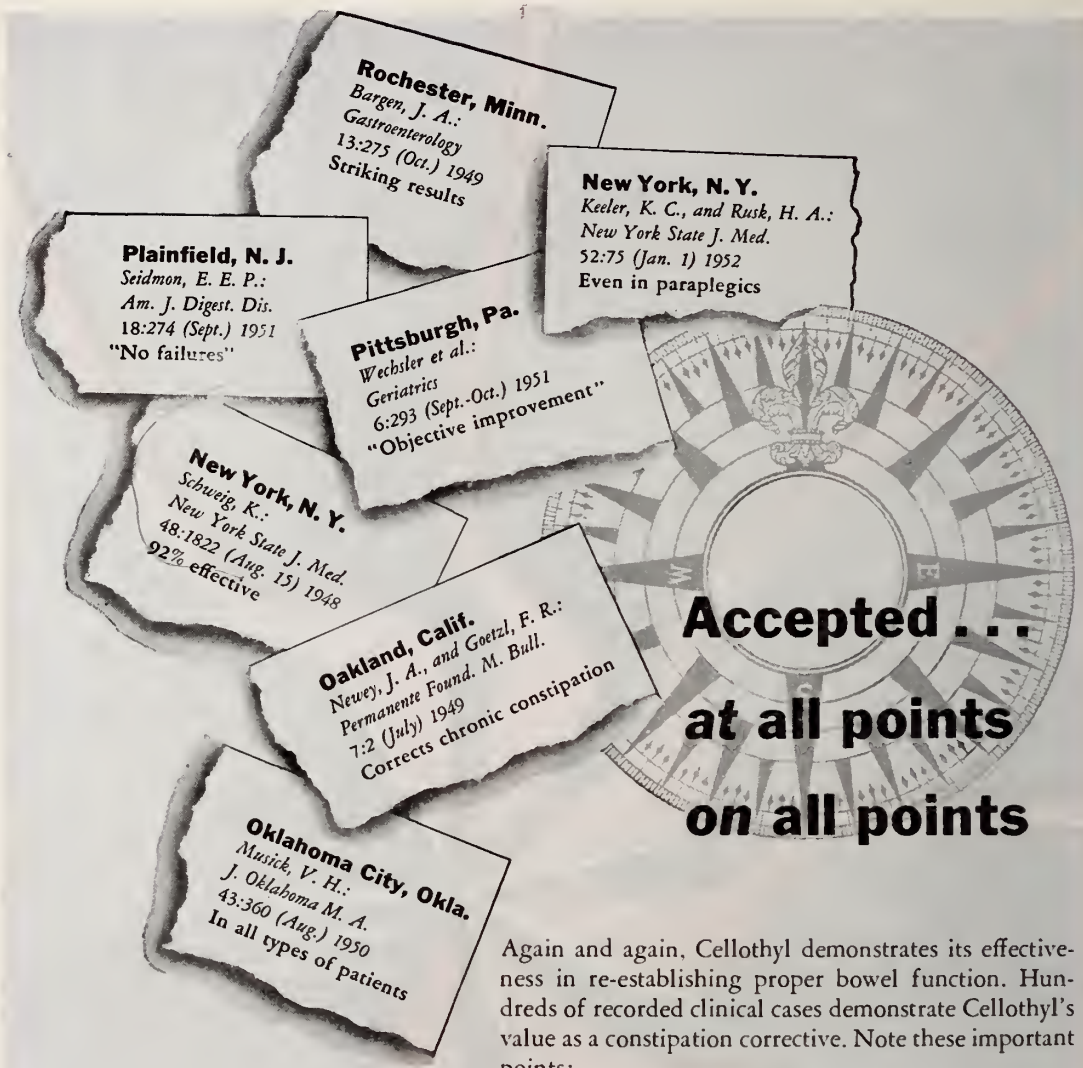

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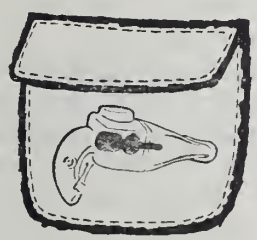
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1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February.
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3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3′,4′-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

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Protein of good quality and in adequate amounts is the most effective dietary agent for protecting the liver from damage and for promoting its repair.[2] In the long-term management of chronic liver disease, a suggested diet includes at least 4 ounces of lean lamb, veal, or beef in both the noon and evening meals.[3]

Among the nutritional needs of patients with chronic ulcerative colitis is protein.[4] For such patients a recommended diet includes 4 ounces of tender meat with luncheon and with dinner.[5a]

In diabetes mellitus, maintenance of protein reserves is important for supporting well-being and vigor, for maintaining resistance to infection, and, in conjunction with good general management, for minimizing many of the degenerative changes commonly seen in this condition.[6,7] One ounce of bacon at breakfast and 2½ ounces of cooked meat at each of the other two meals are valuable in a diabetic diet.[5b]

A program of treatment[8] found useful in atherosclerosis of the coronary vessels includes an adequate diet low in fat (20-25 Gm. daily) and normal or moderately high in protein (60-100 Gm. daily), in conjunction with lipotropic agents. A sample menu of this diet lists 2 ounces of lean meat at both the noon and evening meals.

Underweight or average weight patients with persistent low blood sugar levels are benefited by a high protein diet providing meat two or three times a day.[9] In overweight patients of this type, lean meat is served at luncheon and at dinner.

During convalescence from infectious disease, the importance of "high protein-high calorie" diets including generous servings of meat deserves emphasis.[10] For this purpose, a suggested typical daily menu schedule which results in weight gain, improved vigor, and a restored sense of well-being furnishes ½ ounce of bacon at breakfast and 3 ounces of meat at each of the other meals. Supplementary feedings may include additional amounts of meat.

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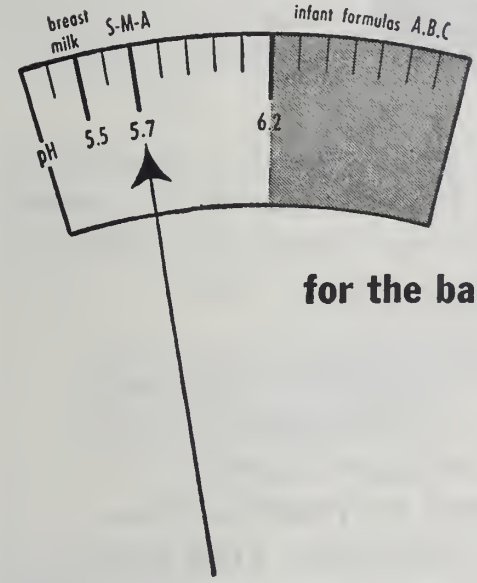
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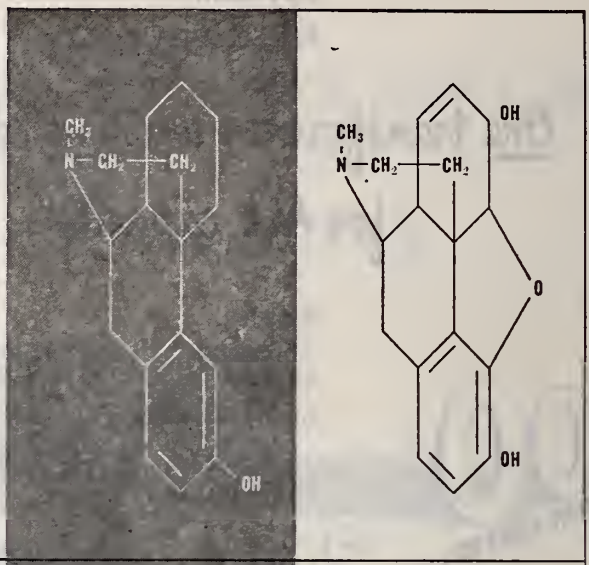
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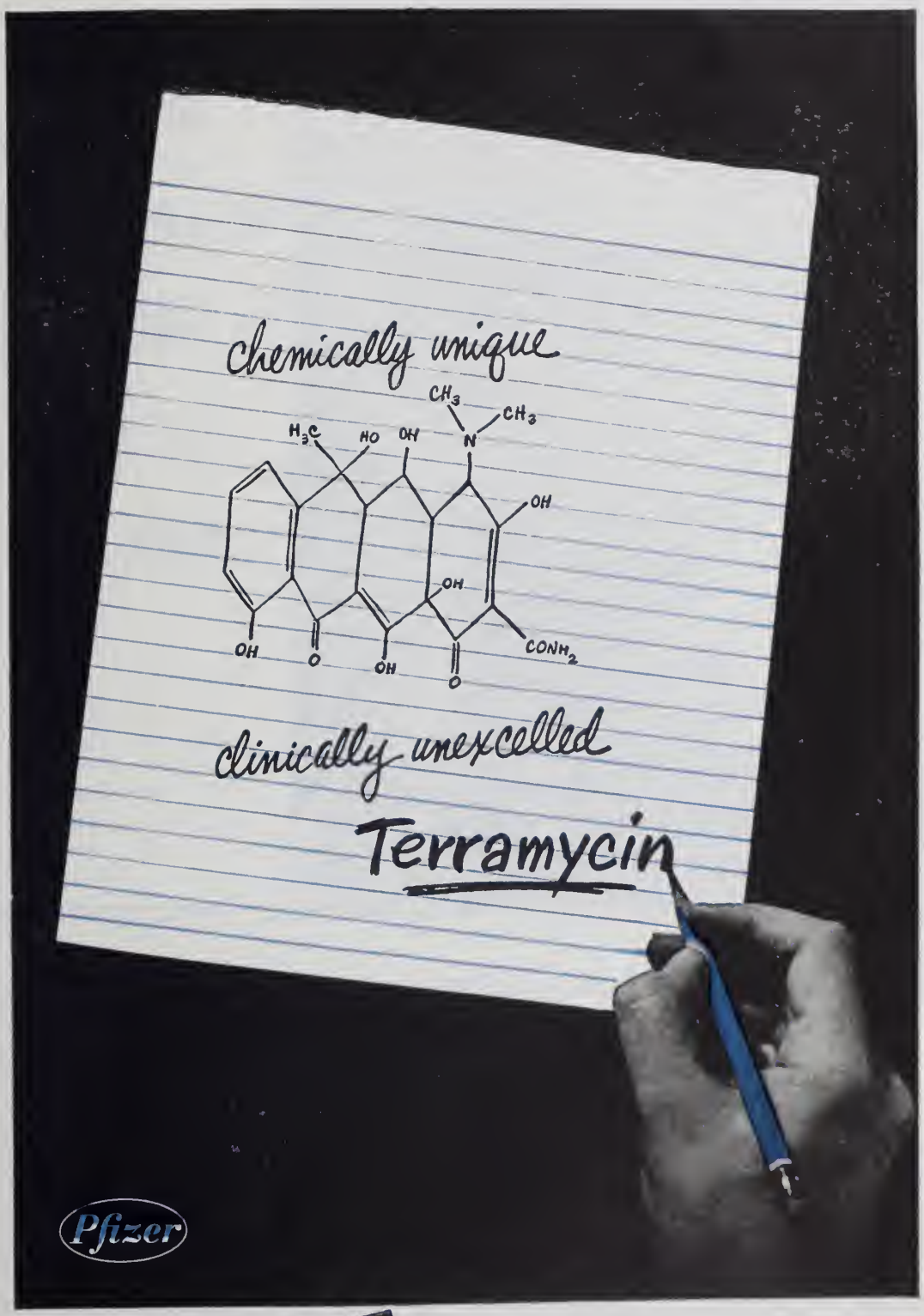
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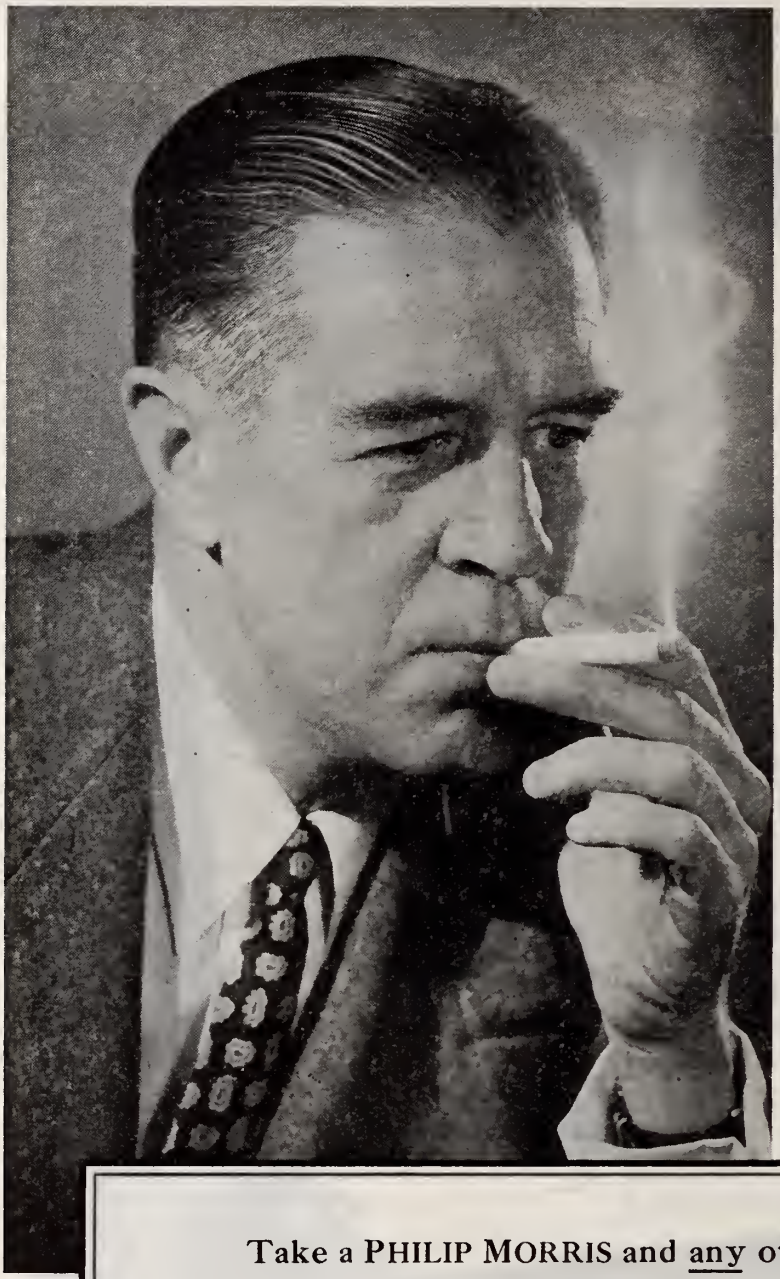
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OF
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J. Lawrence Evans, Jr., M.D.
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Rowland D. Goodman, 2d, M.D.,
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Henry A. Davidson, M.D.,
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Miriam N. Armstrong,
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PRESIDENT'S MESSAGE

SAVE TODAY—FOR TOMORROW

One of the more pleasant duties of the President of a medical society is to attend the meetings of our non-medical friends. This gives your representatives an opportunity to meet civic leaders and discuss with them the many and diverse problems which are so closely allied with medicine. A physician is an important member of the community and as such should enter into the planning for programs designed to help his fellowman.

It was my privilege to have been the guest of Mr. Elmer Bobst, State Chairman of the United States Defense Bonds Drive in New Jersey at a sales promotion dinner in Spring Lake last August. Over two hundred bankers and top business executives representing a cross section of the economic life of our state attended this meeting.

The Secretary of the Treasury, the Honorable John W. Snyder, was the guest of honor and the principal speaker. As I listened to the remarks of several of the industrialists and bankers and finally to those of Mr. Snyder, I was convinced that the professional man too has a stake in this important phase of our country's economic program.

The decision to continue the sale of bonds after World War II was made not merely as a patriotic gesture on the part of the Nation's leading bankers but rather as a stimulation for a definite thrift program that would encourage people to save money. The Bond Program, they decided, would be a very effective brake on the inflationary trend, and the regular and systematic investment in government securities would not only form a reservoir for

the individual's future security but would build a very potent reserve of purchasing power for the stability and prosperity of the Nation.

Doctors do not "just fade away" as it is said of old soldiers. They have to think of the time when perhaps they may no longer be in practice, and it appears to me that the regular purchase of government bonds through the Bond-A-Month plan can appropriately fit into a well planned financial program for every member of our society. Especially for the younger doctor just starting his practice, the Bond Program strikes me as a safe and convenient way to anticipate such problems as the purchase of a home, the building of an educational fund for his children, or the replacement of obsolete equipment.

The promotion of thrift seems to me to be the underlying concept of the Savings Bond Program, but beyond that in a democracy, where every citizen's vote counts, the greatest influence we could have for the encouragement of individual interest in the affairs of our government is to increase the number of individual stockholders in the government.

With increasing taxes and the many demands on his income it is extremely difficult for a physician to save money. With this monthly savings plan Doctor, You can Save Today—For Tomorrow.

HARROLD A. MURRAY, M.D.

HAIL AND FAREWELL

This is the last editorial I shall write for this JOURNAL—at least as its editor. Events have made it necessary for me to move to Washington and I have therefore tendered my resignation.

In these eleven years as editor, I have had a ringside seat at the activities of the high command of your Society. And now that I am leaving, I shall let you in on the inside story. The truth is that your officers and Trustees work unremittingly and at considerable personal sacrifice to discharge their duties. They are men with busy practices who could more pleasantly spend their scant free time at other activities. Instead they come to Trenton or go to committee or county meetings all over the state — sometimes all over the country. Why they do all this is beyond me. Naturally they get criticism, for no one can exercise leadership without that. They lose money, impair their private practices, and deny themselves much personal and family companionship. No desire for individual power motivates them, for the work is so shared, so democratized as it were, that personal dictatorship is impossible. Yet they keep plugging away at it, I know not why. They seem motivated by some sense of mission. Several times in the past decade I have suggested an editorial bouquet for these officers and Trustees—some notice in this JOURNAL of their labors, an expression of appreciation. But this has always been the one editorial they censored. "No", they say "if we let the JOURNAL praise us, they will say that we are just working for personal recognition". So they keep toiling on in behalf of the patients and doctors of New Jersey and no one ever even says: "Thank you". I cannot pass from this scene without recording my observation of the selfless and devoted activity of this group of leaders.

The Society is also fortunate in the caliber of its staff. The average member little realizes the complexity of day by day operations in an office for an organization of 5400 members with a $136,000 a year operating budget. The office must keep its collective eyes on legislation at all levels, on public relations with all sorts of other groups, on scientific progress, on graduate education, on public health

needs, and on the countless other problems that impinge on the health of our people or on the practice of medicine. Indeed, the mere mechanics of internal office operations are tremendous. This includes the handling of mailings, dues, advertising, subscriptions, committee meetings and minutes, building maintenance, arranging conventions and exhibits, writing and distributing releases and many other chores that go with internal organizational management. Few members know about these details, and that fact is a reflection of the smoothness of operations. As with the organs of the human body, they operate best when they are most silent. But this beautifully balanced machine would not function so silently were it not for ace-high staff administration: the Executive Officer, the Administrative Secretary, Secretaries of certain key committees, the Assistant Editor, and an efficient, if too often anonymous clerical staff. It is with real feeling and considerable knowledge of the subject that I salute the hard working staff people who keep the wheels turning.

As I leave Trenton, I cannot but be impressed with the way in which your Executive and Editorial Offices have functioned and it is only fair that I tell you these things. The officers and officials concerned will never do so.

You have in The Medical Society of New Jersey an alert, flexible and democratically sensitive instrument. With a ratio of 15 members per Delegate, you have basic control where it belongs: in the hands of the members. You have here the oldest medical organization in the entire Western Hemisphere. I have always been proud of my association with it. You should be proud of it too. If each member will regularly attend his county society meetings, he can make his voice heard. He has a grand heritage in The Medical Society of New Jersey. I am sorry to have to sever my own official connection with it.

May it always remain, as it has been for almost two hundred years, a voluntary fraternity of the doctors of New Jersey, united to bring to the people, the best in medical care. Maybe I'm prejudiced, but I think it is the proudest and best brotherhood in the state.

Henry A. Davidson, M.D.

SCIRE FACIAS

Diabetes is a disorder which presents an unusual challenge to each physician, a challenge not only in the medical field but in that of public relations. Medically, present day treatment is effective as far as the diabetes itself is concerned, but the complications which may develop have defied most attempts to cope with them. But this we do know. *Early diagnosis of the disease* is the one sure way in which many complications may be avoided. At this point the public relations challenge must be, and has been, met, largely through Diabetes Detection Drives.

Diabetes case-finding has been carried on since 1947, as part of a community diabetes control program in Brookline, Massachusetts. The case-finding procedure comprises three phases: screening, re-examination, and diagnosis. Of 3,186 persons on whom both blood and urine sugar tests were made, 338 (10.6 per cent) had blood sugar readings above the minimum screening levels and 451 (14.1 per cent) had positive urinalyses. It was possible to diagnose diabetes in 71 of the 3,186 persons. If only those subjects with more than a trace of glycosuria (4 per cent of the total group) had been re-examined, only 40 of the 71 cases would have been found. If only those subjects with blood sugar readings above the levels that screened out 4 per cent of the group had been re-examined, 58 of the 71 cases

would have been discovered. By re-examining approximately the same number of persons (4 per cent of the total group) on the basis of the urine sugar screening test and the blood sugar screening test, the specificity of the two tests were compared. Of those singled out for re-examination by the urine sugar test, 35.7 per cent were new diabetics. Of those singled out for re-examination on the basis of the blood sugar examination, 49.2 per cent were new diabetics. It appears that the blood sugar screening test was more sensitive than the urine sugar screening test when equal numbers of subjects were brought back for further testing by each procedure. The increased sensitivity of the blood sugar test was apparently due to its greater ability to detect persons with the milder type of laboratory findings.

This year November 16 through November 22 has been designated as Diabetes Detection Week. An effort is being made to get every person to his personal physician or to a Testing Center for a diabetic test. *Scire facias. Let it be known!*

Our program in New Jersey is not as ambitious a one as that in Brookline, Massachusetts; but we are making the attempt to alert the public to the importance of the early discovery of diabetes and its proper treatment. *Scire facias. Let it be known!* Remind all members of any family you meet. Ask them to spread the word about the Week among their friends and business associates. If anyone has an undiagnosed case of diabetes the screening will bring it to light *now* before it has a chance to become more serious and harder to control. There exists the hope that with the cooperation of the physician and the patient, and with an active and continuing campaign of public education, diabetes may be detected at its earliest stage and brought under effective control.

ARE SIGNS NECESSARY?

The American Medical Association now offers a sign for doctors' offices bearing the legend, "I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

The question arises, is such a sign necessary? True, the basis of a successful medical practice is common understanding between the doctor and his patient. The physician is expected to interpret to the patient the probable diagnosis, the need for special examinations, and the course of treatment. Such interpretation should include a discussion of the cost. If a patient feels reluctant to discuss this, the capable physician will introduce it at the appropriate time. It is difficult to see how a waiting room sign can substitute for good rapport between the doctor and his patient.

Perhaps this sign expresses the concern of its sponsors about the patient's attitude toward the current high cost of adequate medical care. It is the physician's duty to explain to his patient just what he is receiving for his money, how he will benefit from the scientific advances of medicine, or how expensive it is to run a modern hospital with all its laboratory, x-ray, nursing and diet facilities.

If a patient is disturbed by his doctor's handling of his case, or dissatisfied with his services, frank and open discussion will be more productive of the desired results than the mere presence of a sign. Whether the patient feels free to discuss such problems depends primarily on the attitude of the physician toward him, and the atmosphere of their reciprocal relationship.

ORIGINAL ARTICLES

DIAGNOSTIC DIFFICULTIES IN HERNIATED DISK *

Raphael R. Goldenberg, M.D., Paterson, N. J.

Purpose of this presentation is to sound a note of caution in the diagnosis of a suspected herniated intervertebral disk. It is important to remember that lesions other than disk involvement may produce a clinical picture which, for a variable time, will be strikingly similar to that usually seen in the protruded disk syndrome. Although laboratory tests are important diagnostic aids, no laboratory procedure can replace clinical judgment. This is illustrated in the cases presented below:

CASE ONE

A 22-year old unmarried woman had been entirely well up until August 1947, when she developed pain in the lower back. One month after onset the pain radiated down the posterior aspect of the left lower extremity. Pain was aggravated by coughing, sneezing, bending, lifting and long standing. She had been treated by several physicians and in October 1947, she was referred to St. Joseph's Hospital (Paterson, N. J.) because of a suspected herniated intervertebral disk. She appeared to be in good general health. There was a partial loss of the lumbar lordosis. Motions of the spine were restricted and painful in all directions. There was moderate paraspinal spasm. The Naffziger test was positive, reproducing the pain in the lower back and in the left thigh. The straight leg raising and the Brazzard tests were markedly positive on the left. The left ankle reflex was decreased. There was hypesthesia of the fifth toe and of the lateral aspect of the left foot. Tenderness was marked on the left side of the lumbo-sacral region and firm pressure in this area reproduced the pain in the left thigh.

The urine was normal. The hemoglobin was 85 per cent, red blood cells 4.5 million, white blood cells 9350 per cubic millimeter with a normal differential count except for a 6 per cent eosinophilia. X-ray examination of the lumbosacral region revealed suspicious mottling and slight erosion of the left lamina of the fifth lumbar vertebra.

On November 4, 1947, a biopsy of the left lamina of the fifth lumbar vertebra was performed. Microscopic section reported by Dr. Kim revealed that the marrow spaces were partly filled with medium-sized cells which varied in size and shape. There were occasional mitotic figures. The bone spicules were eroded. The primary malignant focus could not be identified from the microscopic examination.

The patient died on January 2, 1948. Autopsy revealed a primary carcinoma of the thyroid gland.

This 22-year old female had a primary carcinoma of the thyroid gland with metastatic involvement of the fifth lumbar vertebra. The clinical picture was similar to that of a herniated nucleus pulposus.

CASE TWO

A 21-year old male was first examined in January 1949, at the New York Hospital for Joint Diseases because of pain in the left lower back. He dated onset of his pain to an injury in 1944 when he had been struck in the lower back. The pain was aggravated by activity and by inclement weather. In 1947, (3 years after onset) the pain began to radiate down the lateral aspect of the left thigh. Because of a suspected herniated disk a myelogram, made at another institution, was reported to be negative. The pain in the back and in the left thigh persisted despite physical therapy and a back brace. He had a slight tilt of the trunk to the right. Motions of the spine were restricted and painful on forward flexion and on right lateral flexion. The pain was localized to the left lumbar region. The Naffziger test was negative. The straight leg raising test was restricted on the left. There was one inch atrophy of the left thigh and one-quarter inch atrophy of the left calf. The knee and ankle reflexes were present, equal and active. There were no motor or sensory changes in either lower extremity. Tenderness was localized to the left side of the first and second lumbar vertebrae.

Cone x-rays of the second lumbar vertebra showed a small area of sclerosis at the base of the left transverse process. Laminagraphs made by Dr. M. Pomeranz confirmed the presence of a sharply defined circular area of density one-quarter inch in diameter at a depth of two and three-quarter inches.

Operation was performed by Dr. Leo Mayer on February 11, 1949, with x-ray control. The nidus was found in the bony wall of the intervertebral foramen and was excised. The second lumbar nerve root was visualized within the foramen.

The pre-operative pain was relieved and has not recurred. Diagnosis of osteoid osteoma was confirmed on microscopic examination by Dr. H. L. Jaffe.

This patient's pain was caused by an osteoma with probable irritation of the second lumbar nerve. This lesion produced signs and symp-

* Read before the Section on Orthopedic Surgery at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1952.

toms similar to those usually encountered in herniated nucleus pulposus.

CASE THREE

This 16-year old girl was seen in consultation because of pain in the lower back with radiation down the right lower extremity of three years' duration. The pain had developed gradually associated with increasing limitation of spinal motion. Within a few months after the onset, the pain radiated down both lower extremities. She had been treated by support, medication, physical therapy, and "chiropractic manipulation" without relief. She appeared to be in fairly good general health. There was a complete reversal of the lumbar lordosis, and marked paraspinal spasm. All spinal motions were restricted and painful. The Naffziger test was positive and reproduced the pain in the lower back and in the right lower extremity. There was bilateral restriction of the straight leg raising tests. The Brazzard test was positive on each side. The double thigh flexion test was painful. The right patellar and ankle reflexes were diminished. There was no atrophy of either the thighs or the calves. There was tenderness over the lumbo-sacral region.

Urine was normal. Hemoglobin was 82 per cent, the red blood cells 4.3 million, and white blood cells 7300 per cubic millimeter, with a normal differential count. Lumbar puncture was believed to be unsatisfactory because bloody fluid was obtained. X-ray examination was negative except for a loss of the normal lumbar lordosis.

An exploratory operation was done. On elevating the muscles from the spinous processes and from the laminae, the periosteal elevator slipped into a defect in the spinal column. The bone edges were smooth. The extradural space was filled with a soft friable tissue which resembled old clots of blood. Most of this tissue could be wiped out of the wound with a sponge. The lesion extended from the twelfth thoracic vertebra down to and through the anterior wall of the sacrum.

Microscopic examination showed rings of papilloma-like structures made up of highly edematous hyalinized stroma covered by layers of small cells with scanty cytoplasm. The tissue was vascular. This is the less common form of ependymoma of the cord, the commoner forms being solid or gland-like. The microscopic slides were reviewed by Drs. G. Kim and Purdy Stout and the diagnosis of ependymoma was confirmed.

The lumbar puncture should not have been rejected because bloody fluid was obtained. Ependymoma is one of the commoner (60 per cent) varieties of spinal cord glioma tumors. An ependymoma is a relatively benign tumor. The course of the disease is slow and progressive. In this instance the patient had pain in the back and in the right lower extremity for three years prior to the operative intervention.

CASE FOUR

This patient sustained an injury to his lower back. He had been treated by the plant physician by physical therapy and medication without relief of pain. X-rays, made a month later, were reported to be "negative for bone pathology". The pain increased and in this four weeks, it was radiating down the left lower extremity. Pain was aggravated by standing, coughing and sneezing, and was relieved by rest in bed.

He showed loss of the lumbar lordosis. The paraspinal muscles were in constant spasm. Motions of the spine were possible through one-half the normal range, but there was pain at the extremes of motions. The Naffziger test was positive. There was bilateral restriction of the straight leg raising test. The double thigh flexion test was markedly positive. Left patellar and left ankle reflexes were definitely diminished. There was hypesthesia of the anterior aspect distal third of left thigh, the lateral aspect of the left calf, the left foot, and of the dorsal aspect of the left great toe. There was diffuse tenderness of the lower three lumbar vertebrae. The point of maximum tenderness was localized to the region of the spinous process of the third lumbar vertebra. Firm digital pressure in this region reproduced the radiating pain in the left lower extremity. The urine showed three plus albumin, with a few pus cells in the sediment. Hemoglobin was 88 per cent, red blood cells 4.6 million, and white blood cells 8050 per cubic millimeter, with a normal differential count. The blood chemistry showed 13.3 milligrams per cent of calcium and 8.6 milligrams per cent of plasma protein. The original x-rays were reviewed and these revealed porosis in the body of the third lumbar vertebra together with destructive changes in the laminae of the third and fourth lumbar vertebrae.

A biopsy of the involved spinal segment was performed. The microscopic section reported by Dr. Kim revealed comparatively small cells, occurring diffusely. Nuclei were of the cart-wheel type and eccentrically placed with a narrow zone on the side of abundant cytoplasm. The stroma consisted of thin fibrous strands, bearing blood vessels. *Diagnosis:* Plasma Cell Myeloma. The patient developed paraplegia 6 months after the biopsy and died four weeks later. Autopsy showed an extensive skeletal and visceral involvement by multiple myelomata.

This 25-year old male had multiple myeloma The presenting signs and symptoms were similar to the clinical picture usually seen in herniated nucleus pulposus. The three plus albuminuria should have been an early diagnostic clue. Multiple myeloma does not usually occur in patients of 25 years of age but has been reported.

CASE FIVE

A 35-year old man was seen in consultation in March 1951, because of a suspected herniated intervertebral disk. The pain began in the lower back while at work in January 1951. Within three

weeks, the pain had begun to radiate down the left lower extremity to the ankle. He had previously been treated by means of intravenous and trigger-point procaine injections, by a support to the lower back and by physical therapy without relief. Pain was relieved by rest in bed. One week prior to admission, he developed a painless and non-productive cough.

He appeared to be in fairly good general health. He walked with a limp on the left side. His back was symmetrical and the spine was in the midline. The Naffziger test was positive. Motions of the spine were complete but the patient complained of pain at the extremes of extension and right lateral flexion. All routine tests for low back derangement were negative. There was no atrophy of the thighs or calves. The left patellar and ankle reflexes were diminished. There was definite motor weakness of the extensors of the left great toe, and hypesthesia of the great, second and third toes of the left foot. Tenderness was marked on the left side of the lumbo-sacral region. Myelographic examination showed a deformity of the pantopaque column with elevation of the nerve root on the left side of the disk space under the fifth lumbar vertebra.

Chest x-ray revealed a tumor clouding of the right lower lung with infiltration of the tumor into the upper lobe. Thoracentesis was performed and 400 cubic centimeters of cloudy yellowish fluid were aspirated. Microscopic examination of the centrifuged specimen by Dr. Kim showed typical cells with irregular nuclei. Occasional acinar arrangement suggested adenocarcinoma.

Diagnosis: Carcinoma, right lung.

This patient had a "silent" carcinoma of the lung which was discovered by accident. Did this 35 year old patient have a disk lesion or were the clinical signs caused by a metastatic focus from the pulmonary carcinoma? If malignancy is present, organic neurologic involvement can usually be attributed to metastatic spread. Laminectomy was not done.

This man had had a red cell count under 4 million and a hemoglobin of only 76 per cent, on several blood counts. This anemia should have aroused suspicion, but it was disregarded.

CASE SIX

This final case is of considerable interest because of the difficulty in establishing a diagnosis. The patient, a 61-year old male, had had two prior episodes of low back pain, the first in 1936, the second in 1942. On each occasion, pain developed gradually without known trauma. Duration of each attack was approximately three weeks. He had been entirely well until September 1950, when the present illness began. The pain gradually increased in severity and was aggravated by bending, coughing and sneezing. He had been treated by physical therapy and medication. In November 1950, the pain began to radiate down the right lower extremity. The pain was relieved by bed rest. The patient was first examined in January 1951. His back was asymmetrical in that there was a thirty degree tilt of the trunk to the right associated with a complete loss of the lumbar lordosis. All spinal motions were painful and restricted. The Naffziger test was positive, reproducing the pain in the lower back. The straight-leg raising test was restricted. There was three-quarters of an inch atrophy of the right thigh and one-half inch atrophy of the right calf. The right ankle reflex was absent. There were no motor or sensory changes in either lower extremity. Hemoglobin 60 per cent, the red blood cells 3.2 million, the white blood cells 7200 per cubic millimeter with a normal differential count. X-rays made on November 6, 1950, (two months prior to hospitalization) were reviewed and showed an increased lumbo-sacral angle and a narrowed disk space above the first sacral segment.

Medical consultation failed to reveal the cause of the anemia. In view of the persistent pain the patient was given two transfusions of whole blood and the hemoglobin rose to 78 per cent. Operation was performed on January 17, 1951. A bulging intervertebral disk was found on the right side of the L5-S1 space and was removed. During the operation an additional half-litre of blood was administered. Postoperative course was uneventful; the pre-operative pain cleared, and the patient was discharged from the hospital on January 27, 1951. It appeared that this was another instance of herniated intervertebral disk satisfactorily relieved by laminectomy. But three weeks later, he was back in the hospital. He had slipped on a sidewalk and the pain in the lower back and in the right lower extremity recurred. Because of persistent anemia the patient was again seen by a hematologist. He believed that the anemia, marked changes in the red cells and the polynucleosis suggested a neoplastic condition, but a definite diagnosis could not be established. Complete x-ray and consultation studies failed to localize any tumor. Myelography at this time showed a definite deformity of the pantopaque column on the right side of the L4-L5 interspace.

Operation was performed on March 26, 1951. There was a herniated disk on the right side of the L4-L5 interspace. This area had been explored and found normal at the first operation. The muscle on the right side of the lower back was markedly thickened, hard and grayish-white in color.

Microscopic examination of the intervertebral disk reported by Dr. G. Kim showed fibrocartilage together with the fragments of tumor cells. The tumor was similar to that seen in the muscles. Microscopic examination of the muscle tissue removed at operation showed alveolar masses and tubules of polyhedral clear cells as seen in renal neoplasm. There were a few mitotic figures.

Diagnosis: Carcinoma of the kidney with metastases to the intervertebral disk and muscle of lower back.

Following the first operation for excision of the bulging disk on the right side of the

L5-S1 interspace, it appeared that the patient had made a complete recovery. Within eight weeks a second operation was performed and a bulging disk on the right side of the L4-L5 interspace was removed. In this interval of eight weeks, the metastatic lesion had involved the L4-L5 disk as well as the paraspinal muscle on the right side.

SUMMARY

Six cases of low back pain have been presented each with a different pathologic diagnosis. In each instance, the clinical picture was similar to that usually seen in patients with herniation of the nucleus pulposus. It is evident that there is no typical clinical picture of the herniated disk. Each patient must be studied individually and completely. Laboratory findings of secondary anemia or albuminuria require further investigation to rule out malignancy. The patient under observation who seems to be another typical case of herniated intervertebral disk may turn out to be a difficult diagnostic problem.

The author wishes to express his appreciation to Dr. Leo Mayer for his kindness and permission to report case 2.

588 East 27th Street

CLINICAL EVALUATION OF A NEW TYPE OF LIVER EXTRACT

Charles D'Amato, M.D., East Rutherford, N. J.

Liver extracts are valuable in the treatment of anemia. They stimulate improvement in the blood picture, and also promote the patient's general health and well-being. Investigators have emphasized their preference for parenteral therapy over vitamin B_{12} because of the various factors in present liver extract besides vitamin B_{12} which seem to contribute to the general clinical improvement.

In the past, I have experienced considerable difficulty in the use of the parenteral liver extracts because of the pain caused by injection. Apprehensive patients, particularly, are very intolerant of this pain. In many cases I have had to discontinue this form of treatment because of this reaction.

Recently, a new type of parenteral liver extract was reported as being painless even when injected subcutaneously into the arm. This preparation is Pernaemon.* In attempting to evaluate both the "painless" factors and the therapeutic effectiveness of this liver extract, I tested the preparation in a series of twelve anemic patients whose response to liver extract therapy had not been satisfactory because of painfulness and/or inadequate blood improvement. In these patients, previous treatment, for the most part, had been with other parenteral liver extracts, both crude and purified. Vitamin B_{12} was used in a few cases, and oral hematinics were occasionally prescribed as adjunctive therapy. The average dose of liver injection was one cubic centimeter of 15-unit liver extract two to three times a week; of crude liver extract, one cubic centimeter of 2-unit liver two to three times a week; of vitamin B_{12}, 30 micrograms two to three times a week. In all of the patients reported in this series, response to these forms of treatment was not satisfactory, and in all cases, the painfulness of the injections of liver extract was considered by the patient to be a definite handicap to continuing with treatment.

The average dose of Pernaemon* (15 unit U.S.P. liver) was 2 cubic centimeters two or three times a week for the first month, decreased at the end of that time to 2 cubic centimeters once a week. Most striking result was the relief these patients experienced at the painlessness of the injection. Also conspicuous was the improvement in the blood picture and in the clinical status.

The following case summaries give the results obtained:

* Pernaemon, a 15-unit U.S.P. liver extract, is standardized so that each cubic centimeter provides vitamin B12 activity of at least 20 micrograms of cyanocobalamin. Pernacmon is manufactured by Organon Inc., of Orange, N. J.

1. Age 46. Post-traumatic diabetic, gastric ulcer. R.B.C., 2,890,000; hemoglobin, 56%. Response to 15-unit U.S.P. liver, 1 c.c. three times a week for six weeks, was not satisfactory. The patient objected to the painful injection. Pernaemon* treatment was started with dosage of 1 c.c. daily for four weeks, then 1 c.c. three times a week. Results were excellent: R.B.C., 3,840,000; hemoglobin, 73%. There was no pain on injection.

2. Boy, age 2. Secondary anemia. R.B.C., 3,200,000; hemoglobin, 62%. Initial treatment with oral hematinics, and 30 micrograms of vitamin B_{12}, two to three times a week for four weeks. Response was poor. Started on Pernaemon* therapy: 1 c.c. daily for five days; then 1 c.c. three times a week for four weeks, and 1 c.c. weekly. Response was very good. R.B.C., 4,200,000; hemoglobin, 79%.

3. Boy, age 4. Secondary anemia of unknown cause. Blood picture: R.B.C., 2,950,000; hemoglobin, 60%. Vitamin B_{12}, 30 micrograms twice a week, with oral hematinics, was employed, but the results were poor. Pernaemon* therapy was started with 1 c.c. daily for five days; then 1 c.c. twice a week to April 28, 1952. Results were excellent: R.B.C., 3,800,000; hemoglobin, 75%; and there was no pain on injection.

4. Age 61. Secondary anemia of unknown cause. Blood picture: R.B.C., 3,700,000; hemoglobin, 70%. U.S.P. liver (15 units) was injected in a dose of 2 c.c. a week for 8 weeks. The patient objected to the painful injection, and since results were not satisfactory, Pernaemon* therapy was started in a dose of 2 c.c. twice a week. R.B.C. has improved to 4,300,000; hemoglobin to 82%. There was no pain on injection.

5. Age 38. Pregnancy anemia. Blood picture: R.B.C., 3,200,000; hemoglobin, 64%. Initial treatment with crude liver, 2 units three times a week. Results were very poor. Pernaemon* therapy was started in a dose of 2 c.c. twice a week for four weeks, then 1 c.c. a week. The patient commented that she liked the painless injections. The improvement in R.B.C. to 3,980,000; and hemoglobin to 76%, were better than anticipated.

6. Age 68. Pernicious anemia. Blood picture: R.B.C., 3,740,000; hemoglobin, 72%. Response to U.S.P. liver, 15 units three times a week for five weeks, was fair; however, the patient complained of pain on injection. Pernaemon* was started, 2 c.c. three times a week; then 2 c.c. per week. The R.B.C. has increased to 4,450,000; the hemoglobin to 83%. Results are considered excellent, and the patient is pleased with the painless injection.

7. Age 33. Secondary anemia due to blood loss. Blood picture: R.B.C., 3,200,000; hemoglobin, 62%. Initial treatment consisted of injections of 2-unit crude liver three times a week. The results were inadequate; again the patient complained of the painful injection. Pernaemon* treatment was started in a dose of 1 c.c. per day for five days, then per week for three weeks. The patient was much improved: R.B.C., 4,000,000; hemoglobin, 79%. Painlessness of the injection was conspicuous.

8. Age 32. Postpartum secondary anemia. Blood picture: R.B.C., 3,400,000; hemoglobin, 64%. Treatment involved the use of oral hematinics, and a 15-unit parenteral liver extract two or three times a week. After three weeks' therapy with Pernaemon* in a dose of 2 c.c. weekly, after initial therapy proved unsuccessful, the R.B.C. was 4,200,000; the hemoglobin, 83%.

9. Age 25. Secondary anemia. Blood picture: R.B.C., 3,600,000; hemoglobin, 71%. Oral hematinics and crude liver injections (2 units two to three times a week) were given for six weeks, but results were poor. Pernaemon* was started in a dose of 2 c.c. twice a week for three weeks, then once a week for nine weeks. At the end of that time, R.B.C. was 4,200,000; hemoglobin, 84%. The patient experienced no pain on injection.

10. Age 32. Postpartum anemia. Blood picture: R.B.C., 3,300,000; hemoglobin, 67%. 15-unit U.S.P. liver was injected in a dose of 1-2 c.c. three times a week. Results were not satisfactory; the patient complained of the pain of the injection. Pernaemon* was started; dosage was 2 c.c. three times a week for 6 weeks. The patient experienced no pain. At the end of treatment, R.B.C. was 3,950,000; hemoglobin was 67%.

11. Age 42. Secondary anemia. Blood picture: R.B.C., 3,600,000; hemoglobin, 67%. Treatment with 15-unit parenteral liver was initiated; injections were made three times a week for four weeks. Because of insufficient response, Pernaemon* treatment was started in a dose of 1 c.c. four times a week for three weeks, then 1 c.c. a week for five weeks. R.B.C. was 4,300,000; hemoglobin, 79%. Response was excellent and without pain

12. Age 13. Chlorosis; diabetes. Blood picture: R.B.C., 3,150,000; hemoglobin, 62%. Oral hematinics and crude liver, 2 units twice a week for five weeks, produced a poor response. Pernaemon,* started in a dose of 2 c.c. three times a week for four weeks, then 2 c.c. a week for five weeks, produced an excellent response; furthermore, the injections were painless.

CONCLUSIONS

Pernaemon* is a welcome improvement over liver injections presently available. In a series of twelve patients treated with this new liver extract, clinical response was excellent. None of the patients complained of pain; in fact, most expressed their pleasure at the painlessness of this new type of liver therapy. Amelioration of the blood picture as well as subjective improvement often exceeded that obtained with other types of liver injections or vitamin B_{12} injections. This preparation appears to represent a much-needed improvement in parenteral liver extracts.

324 Hoboken Road

NUTRITION AND METABOLISM IN HEALTH AND DISEASE

BASED ON A REVIEW OF THE GILLMANS' BOOK* "PERSPECTIVES IN HUMAN MALNUTRITION"

Harold E. Lippman, M.D., Newark, N. J.

In the guise of an excellent and critical review of pellagra and malnutrition, the Gillmans[1] have written an extraordinary and penetrating analysis of our current knowledge of metabolism. This work has deep implications for all fields of medicine. The Gillmans have had intimate experience working in South Africa with pellagrinous natives, and give the subject the freshness yet depth which only such day by day experience can afford. To this they have added an exhaustive and critical review of the pertinent literature to and through 1948. This has been worked into a living, a dynamic philosophy of medicine—a philosophy in which the inter-reaction of complex factors on living biologic system is seen as a "dialectic" rather than as a mechanical or "organistic" action and reaction pattern.

This is fundamentally a study of pellagra, a disease of protean manifestations, which causes changes, often irreversible, in all organs and organ systems; and what is more basic, is associated with changes in the living metabolism of the whole organism and its parts—down to the individual cell, as well as to the noncellular and subcellular elements and to the enzyme systems.

The Gillmans have abandoned the generally accepted linkage of signs and symptoms with specific dietary deficiencies. They feel that extrapolation from single factor experiments are usually invalid and have led to ". . . the erroneous impression that the grave effects of chronic malnutrition can easily be reversed without a radical improvement of the inadequate diet consumed by malnourished peoples".

The objectives of *Perspectives in Human Malnutrition** are trifold: "The first is to focus attention on the changing patterns—of chronic malnutrition and of pellagra in the Johannesburg African (Bantu) at various periods of life. The second is to assess the clinical and pathologic findings, at different stages of the syndrome, in terms of modifications in physiologic regulations . . . third . . . to examine the possibility . . . that chronic malnutrition . . . affects the life-track of individuals in such a way as to facilitate the emergence of some diseases, not usually regarded as etiologically related to nutrition, while excluding others."

It is this final objective which makes this work of such deep significance to all men of medicine.

A basic contention of this work is that malnutrition leads to changes in metabolism and in the physiologic regulations of the organism resulting eventually in clinical and pathologic changes.

In the chapters on environment and malnutrition, the Gillmans point out that tropical and winter climate in the temperate zone have a pellagra preventive action. Solar activity within certain maximum and minimum limits is a requisite for the transformation of malnutritional states into pellagra. Although there is an evident direct effect on the skin, (as, for example, Casel's necklace[2]), the question of the alteration of metabolism by light acting on the pituitary through the optico-hypothalamic pathways remains unanswered by the authors. They do point out that a sudden rise in atmospheric temperature may so upset the regulations of the pellagrins that features of pellagra, or in extreme cases, heat stroke, may develop.

After discussing the epidemiology of pellagra, the Gillmans depict the complete developmental pattern of the disease from the pella-

*This article is a critical review of the book *Perspectives in Human Malnutrition* by Joseph Gillman, M.D. and Theodore Gillman, M.D., published last year by Grune and Stratton in New York.

1. Dr. Joseph Gillman and Dr. Theodore Gillman are professors in the departments of anatomy and physiology at the medical school of the University of the Witwatersrand in Johannesburg, South Africa.

2. Casel's necklace is a dermatitis of the circumference of the lower neck, generally considered a manifestation of pellagra.

grinous infant to senility at forty. They show the fundamental differences in manifestations at different periods in the life-track. Each organ or tissue of system discussed is considered in relationship to all other systems at different stages in the life-track.

There is a thorough discussion of the functional relationships of the skin to the internal organs and endocrine glands. Pellagra may resemble myxedema in skin, mental, and thyroid changes. The complex inter-relationship of skin, endocrines, and liver is thoroughly discussed.

There is a complete analysis of the skin in relation to the alimentary tract, and the nervous system. The conclusion of the sections on the skin may well bear application to other disorders involving skin: ". . . *the evidence here presented leads us to conclude that any disturbance in the functional relationship between the skin and the rest of the body may alter the reactivity of the organism as a whole.* This means that in pellagra the nature of the dermatosis can influence the future course of the disease process."

Because it is an organ central to metabolism, and because of the close association of hepatic fibrosis and liver disease with malnutrition, the Gillmans undertook exhaustive studies of liver pathology and physiology in their pellagrinous patients. The Gillmans have done much original work which is exemplary in thoroughness and objectivity.

The Gillmans were impressed by the high incidence of Crooke cells, highly vacuolated beta cells, in the pituitary glands of the African Bantu. They correlated these cells with chronic malnutrition, liver disease, and depressed thyroid, adrenal or gonadal function. They also found iron pigment in the gland cells, multinucleated gland cells, colloid cysts, and general atrophy of the entire pituitary.

The pituitary influences protein, carbohydrate, fat, water and mineral metabolism, growth and reproduction. In the pellagrin, relapses will occur as long as the pituitary is hypoactive because a chronic pellagrin is incapable of utilizing good food.

The Gillmans observed that the clinical signs and symptoms of pellagra assert themselves only with the framework of progressive atrophy and destruction of the endocrine glands. Whereas, the normal organism will have a wide range of adaptability, the pellagrin often has so little adaptability, that special circumstances may be necessary for survival. Extremes of diet and environment may result in serious reactions. Thus:

"Once the pituitary is severely injured, the animal can no longer use food in the same way as a healthy animal. The food is put to different uses, especially since many biologic potentialities can no longer be realized.

"A pellagrin cannot withstand the vagaries of the environment and the inadequacies of the diet imposed by poverty. Relapses occur, and become more frequent as the endocrines deteriorate further. Disease of the pituitary might thus account for the incurable nature of pellagra."

The metabolic processes associated with sex maturation appear to have a pellagra-preventive effect in the African. Once sexual maturity is attained, conditions are apparently optimum for the emergence of pellagra. Pellagra is in some way associated with the effects on the metabolism of the steroid hormones.

The neurologic manifestations of pellagra are wide and varied. In the cord, subacute degeneration occurs, as well as lesions of the lateral column, posterior column and pyramidal tract. There may be atrophy of the cerebrum, cerebellar cortex, or any of the brain nuclei. The fundamental pathology is a primary degeneration of nerve fibers with secondary proliferation of neuroglia. If the metabolism is inadequate, the brain cannot mediate adjustments to the environment. These adjustments may be either gross bodily movements or the subtle adjustments of metabolism—the latter effectuated through the hypothalmic-pituitary endocrine and autonomic systems.* Damage to the brain and nervous system (as to the endocrines) leads to progressive restriction in metabolic patterns. The greater the damage to the brain the less the likelihood of "cure" with the present forms of therapy.

"Speransky and his collaborators altered the nervous system by special technics so that an irreversible dystrophic process could be initiated by a trivial stimulus. This process was associated with oral, nasal, ocular, respiratory, and gastro-intestinal lesions, and terminated fatally. During the course

of this remarkable reaction almost every organ was sooner or later drawn into the pathologic process. These experiments revealed that the entire organism could be subordinated to the march of events initiated by a disordered nervous system."

Applying this to pellagra, we can explain many of the odd features of this syndrome in terms of disease of the nervous system, just as other clinicians have explained it as an endocrine syndrome, or a gastro-intestinal syndrome, et cetera. For the Gillmans it is a question, fundamentally of metabolism, modified by the condition and history of all the systems and all parts of the body, and further modified by the position of the individual evolving human system on its particular "life-track". On one point in its "life-track" the human system may react positively to a specific stimulus. At an adjacent point in time the reactivity of the organism may be so different that there is a negative reaction to the same specific stimulus. This is elaborated on in the discussion of the Adaptation Syndrome, as popularized by Selye.

In addition to the Adaptation Syndrome, the Gillmans point to the macromolecular syndrome as a theory of importance in the pathogenesis of malnutrition. They show that most lesions in malnourished Africans represent, in part at least, perversions of the connective tissue generally.

One of the fundamental philosophical principles applied by the Gillmans in their monumental work is the principle that the whole is greater than the sum of its parts. It is impossible to predict the reactivity of a biologic system in terms of the properties of its parts. The integration of the parts brings new characteristics, new factors and new relationships. The organism is a living dynamic whole in a dynamic setting. The organism cannot be divorced from its environment without changing the organism—its reactivity and its requirements. Likewise, we cannot divorce heart, liver, or other organs from the total living organism.

Another key principle is that the same dietary factor may have different effects on the organism depending on the specific conditions of existence of the organism; its past history, its position on its life-track and its metabolic momentum.

The concepts—"life-track" and metabolic momentum are of tremendous value in the understanding and treatment of all diseases. The life-track is the pathway taken by an evolving organism, constantly interacting with its environment.

Having adopted a philosophy of science and medicine which they felt could explain the field of many conflicting facts—pellagra and malnutrition with its ramifications into all of medicine—the authors have thoroughly analysed all the factors associated with nutrition. The definition of pellagra—as protean as the manifestations of that disease; the effect of climate, sunlight, distance from poles and equator; and the effect of the diet, of maize, and of specific substances.

In a manner which should be a model for all medical writing, they interweave the clinical and pathologic findings as they affect all the organs and the metabolic inter-relationship between the organs. The lesions of the skin are abundantly discussed and are correlated with the changes in stomach, liver, nervous system and endocrine glands. The liver, as a chief organ of metabolism, is discussed with the pathologic changes observed, experiments in pathogenesis and its inter-relationship with all other organs. The other organs are also analysed in this manner.

In view of the present excessive trend towards specialization among medical practitioners, these ideas assume added importance. A correct fundamental understanding of many disease processes will accrue to the doctor who maintains a well-rounded knowledge of the human system as a whole, rather than to one who can see only the "particular physiologic facet" provided by the field of vision of his specialty.

The authors highlight the importance of the metabolic history. They show that even relatively mild pellagrins (those without irreversible changes) may continue to have recurrent attacks for years despite "specific treatment" and change of diet. Their contention is that the "metabolic momentum" is responsible. New metabolic patterns are acquired using new substrates, new enzyme system relationships are established—these new metabolic patterns are often not easily changed. Attempts to change

them before alternate pathways of metabolism are ready, may be disastrous. For instance, excessive vitamin therapy may kill a pellagrinous infant. They clearly demonstrate that a "constellation of physiologic processes are required to permit any reaction to declare itself". "Nutritional diseases like rat-tail dermatitis, rickets, and hemorrhagic cirrhosis of the liver and kidneys can be produced only when the correct dietary setting is provided. In fact, unless certain substances are included in the diets these lesions cannot be evoked".

This work effectively demolishes the specific deficiency concept of nutritional disease. This concept was that lack of a particular food factor causes the specific disease; availability of the factor prevents the disease. The authors show that lack of niacin and/or tryptophane is *not* the sole cause of pellagra; and that addition of these factors do not prevent or cure pellagra. The complexity of the physiologic factors in pellagra is too great to be dependent on only one dietary factor.

Of primary importance in the work is the integrated and consistent, basic philosophical system. Endocrinologists, internists—perhaps most of us accustomed to think in terms of organs as "isolates" will find much to mull over in this book. The implications for medicine in general are gigantic. *"Perspectives in Human Malnutrition"* is not a misnomer. The work contains scores of perspectives, each of which is worthy of an investigation similar to that accorded pellagra: the question of the varying constellations of disease with various diets in different parts of the world; spectacular differences in incidence of cancer, ulcers and hypertension.

Although this work was concerned primarily with nutrition, the authors were evidently aware of its fundamental theoretical implications. The discussion of the General Adaptation Syndrome and the macromolecular syndrome suggest that the Gillmans are searching for a basic medical philosophy. It is my opinion that, although they have contributed an immense segment to this, they have fallen short by failing to attribute adequate weight to environmental factors, especially those environmental factors mediated through the hypothalamic-pituitary axis.

The emphasis on physiology and metabolism points up the need for more thorough use of the fundamental biologic sciences in the problems of medicine. Thus comparative physiology can be of great help in those conditions in which the organism finds it impossible to function on its normal levels and must retrogress to forms of metabolism and physiology similar to that indigenous to lower forms.

One of the basic contributions of this book is the idea that whatever the disease, the nature of the diet, the nutrition, or malnutrition, is of necessity a factor. This is a concept which perhaps should be brought to the attention of those most remote from it: the psychiatrists and psychosomaticists. It is an idea of value in all fields of medicine. We are all too narrow, too encased within the shells of our specialties. Despite its forgivable incompleteness, this book of necessity must broaden us and make us more aware of the complexity of human life.

SUMMARY

From a study of pellagra, the Gillmans have reached a new philosophic level in the field of medicine. They have discarded all teleologic concepts in the etiology of disease. At the same time they have discarded the oversimplifications inherent in "specific deficiency concepts". The metabolism of the organism is the basis upon which all development, health and disease is based. Various states of nutrition and malnutrition are said to alter the metabolism in such a way as to favor or militate against the development of certain diseases. The implications of the ideas advanced in *Perspectives in Human Malnutrition** permeate into every field of medicine.

68 Elizabeth Avenue

AIR POLLUTION: A NATIONAL PROBLEM

Robert B. Marin, M.D., Montclair, N. J.

Air pollution is a multiple problem involving public relations, engineering, good housekeeping, morals, economics and politics. Regardless of what it depends on or how you look at it, one thing is sure: it affects us all. Air pollution is expensive, it damages our homes, our crops, and our health. Contaminants may alter the normal life process and discolor and reduce the yield of the crops. Some polluants sour the soil, throughout the years others may devoid an entire area of vegetation. Smoke damage each year costs Pittsburgh $10,000,000, Cincinnati $8,000,000 and Cleveland $6,000,000. In all about $100,000,000 a year is being spent in the United States on dust suppression methods.

Modern sanitary methods, while decreasing the community odors of the past, have proved largely ineffectual in controlling the compounds used or manufactured in industry. Since we cannot reject air, it becomes increasingly obvious that health is dependent upon not only the food and water ingested, but also on the quality of the air breathed. Because of this human effect, interest has been focused on problems of air pollution in various sections of the country. Atmosphere in growing population centers perversely shows the same inability to dispose of a real waste as exhibited by our polluted rivers and streams. These impurities include smoke, dust, fumes, gases, and the by-products of human activity. The source may range from the local factory stack or municipal dump to oil burners, incinerators and automobiles. All are important. All create air pollution.

While John Q. Public has long accepted smoky air as part of urban living, rebellion is in the offing. Poor visibility, grime and smell are no longer welcomed as signs of economic wealth and well being. Disasters such as those in the Meuse Valley of Belgium in 1930, and Donora, Pennsylvania, in 1948, have focused public attention on air pollution and the danger which lurks in the haze. Mills,[1] reports that pollution of city atmosphere constitutes a health problem of the first magnitude and completely over-shadows such factors as inadequate housing, over-crowding, and poor nutrition. Health-giving sunshine is lost, fogs intensified, buildings soot-streaked, clothing and furniture soiled, and lungs blackened. The attitude and the efficiency of the individual are impaired. The amount of ill health among people subject to air pollution for prolonged periods is significantly greater than the amount of ill health among people living in areas relatively free from air pollution. Dorn[2] feels that the deleterious effects of air pollution upon humans may be marked, and that much sickness due to air pollution is erroneously attributed to a variety of diseases. That the state of health is involved can be attested to by the suffering public in smog ridden areas. Running and burning eyes, repeated respiratory infections, chronic sinusitis, asthma, and chest diseases all are on the rise in polluted areas; and all graphically attest to the effects on the individual. Incidents of large numbers of people in various sections of the country becoming ill from inhaling toxic fumes are all too numerous.

Four areas of the United States are, at present, the principal targets and therefore the principal source of air pollution investigation and information. These are the Los Angeles-Pasadena area, the New York-New Jersey (metropolitan) area, Pittsburgh and the Detroit area. All four have rapidly expanding civilian and industrial concentrations and are in areas conducive to persistent atmospheric inversion. All are located in districts having

1. Dr. Clarence Mills is Professor of Experimental Medicine at the University of Cincinnati.
2. Dr. Augustus Dorn of National Cancer Institute, U. S. Institute of Health, Bethesda, Md.

either a high relative humidity or an adjacency to river valleys or mountain barriers restricting the flow of air. In such areas, air pollution takes place to a depth of thirty miles, depending on wind and drift.

The control of air pollution is complicated by its complexity of cause. No longer is smoke control enough. Serious consideration must be given both to visual polluants such as fly ash and soot, and to invisible polluants such as nitrogen oxides, sulfur oxides, hydro-carbons, aldehydes, acids and radio-active contaminants. Research[3] shows a daily discharge of over 50,000 tons of various materials to be the principal cause of smog in Los Angeles County. Compare these 50,000 tons with a monthly average of 79 tons per square mile deposited in the New York-New Jersey (metropolitan) area! How such a huge daily atmospheric chemical reaction affects humans is a matter of serious conjecture.

Menzies[4] quotes from a newspaper article, "One of today's most pressing problems in public health is air pollution. There is an insistent demand on the part of the people of all communities to clear the air of industrial waste. There is cautious desire on the part of most industries to control it, and an apparent and deep desire on the part of many organizations, technical and scientific societies and professions to participate in this new activity in the field of public health."

Just where the medical profession fits this picture is frequently a tender point with a slowly arousing citizenry. Right or wrong, there is a general feeling that leadership in a problem so intimately connected with public health should develop among those most interested in its preservation: the doctors. It is heartening to report that in scattered areas throughout the United States the profession has already made significant contributions. Research in many of the problems is being actively conducted by local and national groups, as well as by public health teams from various states. A solution will come about only from a cooperative civilian and professional effort. How high we value public health may dictate the course. In the meantime, the people, as they should, look to the medical profession on all levels, local, state, and national, to dedicate their efforts to the solution of one of the most pressing problems in public health that this nation has ever faced.

85 Park Street

ARMED FORCES RECOGNIZE "F.A.C.S." AS SPECIALIST QUALIFICATION

That the medical services of the Armed Forces have, for some years, recognized only certification by an American Board as qualification for rating as a specialist has been a source of considerable dissatisfaction among fellows of the American College of Surgeons. Some two months ago, request was made for recognition of the American College of Surgeons as an acceptable accrediting body in surgery and the surgical specialties. The following reply has been received by the Director of the American College of Surgeons:

Your recent communication requesting that Fellowship in the American College of Surgeons be regarded as full qualification for the rating of specialist in the Armed Forces Medical Services, was presented to the Armed Forces Medical Policy Council at its meeting on July 21, 1952. The Council members were in complete agreement that the educational and training prerequisites to Fellowship in the American College are in accord with the highest professional standards.

You may be assured that Fellows of the American College who are in the Armed Services will be given full recognition for the efforts they have expended in attaining their position, and every effort will be made to assign them as specialists in accordance with their professional training.

I am most appreciative of this opportunity to assist in the full recognition of the high standards of the American College of Surgeons.

Yours sincerely,

MELVIN A. CASBERG, M.D.
Chairman
Armed Forces Medical Policy Council

3. At the Research Institute of Leland Stanford University.
4. J. R. Menzies, Department of National Health and Welfare, Dominion Government, Ottawa, Canada.

CHRONIC THROMBOTIC OCCLUSION OF THE ABDOMINAL AORTA *

BRUCE J. CARROLL, M.D., HAROLD S. YOOD, M.D., and SAMUEL H. SCHWARTZ, M.D., Plainfield, N. J.

In the past few years, increased attention has been paid to the recognition and diagnosis of gradual thrombotic occlusion of the terminal aorta. This is not to be confused with the readily diagnosed syndrome of massive embolization of the abdominal aorta, a dramatic condition requiring prompt therapy if limbs and life are to be saved. Nor should it be confused with an embolic obstruction of iliac or femoral vessels followed by a retrograde thrombosis.

The first reference to aortic thrombosis was by Barth[1] in 1848. Welch[2] fifty years later reviewed the problem and found only 14 cases on record. Leriche[3] in 1940 and again in 1948[4] classified the clinical picture of insidious thrombosis. Since then many cases have been reported. In 1947 Price and Wagner cited 2 cases.[5] Elkin and Cooper[6] in 1949 reported ten cases. In 1950, Ortner[7] reviewed a series of three cases diagnosed by abdominal aortography. Goodwin and Petrie[8] in 1950 analyzed 25 cases (including Elkin's ten cases) reported since 1940. Milanes[9] in 1950 reported 13 cases of Leriche's Syndrome. Four more cases were added by Elliott and Peck.[10] Recently at the Cardiovascular Clinic at Muhlenberg Hospital we had occasion to diagnose and treat one case of Leriche's Syndrome.

A 68-year old male was admitted to the Muhlenberg Hospital complaining of weakness and of discomfort in the right groin after lifting heavy weights. A year before he had had bronchitis and pleurisy. On admission his pulse was 70, his blood pressure 200/90 and his peripheral arteries were tortuous and hard. Cardiac apex was felt in the mid-clavicular line at the fourth interspace. Except for bilateral varicosities, there were no other abnormalities of peripheral circulation. The discomfort in the right groin turned out to be due to a right femoral hernia which was repaired by herniorrhaphy. His postoperative course was uneventful.

Some time later he came to the cardiovascular clinic with a history of intermittent claudication manifested by pain in the calves and soles of both legs. His walking was limited to a single block. This disability had been getting progressively worse. He also reported increasingly severe "rest pain" at night. He smoked one pack of cigarets daily.

At this time his pulse was 60 and his blood pressure was 160/90. The extremities were well developed. Lungs were emphysematous. The legs felt cooler than normal, and showed faint mottling which developed a mild cyanotic tinge after standing. Varicosities were present in both legs. Femoral, popliteal and dorsalis pedis pulsations were absent bilaterally. No oscillometric readings were obtained on the left thigh, calf or ankle; and only faint pulsations were noted on the right calf.

Heart sounds were distant and of poor quality. The apex was in the fifth interspace at the midclavicular line. No murmurs or thrills were heard or felt. There was no evidence of peripheral congestive failure.

Electrocardiogram showed branch bundle block on the right. The ballistocardiogram report was: "Minimal respiratory variations; HI of small amplitude; J prominent with small K. *Impression:* An unusual pattern, suggestive of aortic obstruction. Although abnormal, this is not typical of coronary nor of hypertensive disease".

Radiographic examination showed calcification of the aortic arch. The cardiac shadow was not enlarged. X-ray of the abdomen showed marked calcification of the adominal aorta and of the iliac vessels. There was no evidence of aneurysm formation.

An aortogram was done. The dye was injected just above the splenic artery. There was good visualization of the abdominal aorta, splenic, renal and mesenteric arteries. No dye was noted in the illac vessels, nor was there any change in their roentgenographic appearance.

The blood count showed 4,020,000 red cells and 8800 leucocytes. Urine analysis was negative.

Bilateral lumbar sympathectomy was done. The 12th rib was removed bilaterally and there was dissection and removal of the last thoracic and first four lumbar ganglia. This resulted in marked increase in the warmth and color of the left leg. He is now able to walk at least four blocks without discomfort. He no longer has night cramps or "rest pains".

This case is presented as of interest in view of the availability of more exact aids in the diagnosis of a previously rare syndrome.

* From the Cardiovascular Clinic, Muhlenberg Hospital, Plainfield, N. J. Dr. Samuel H. Schwartz, Director.

1. Barth: Bull. Soc. Anat., Paris, 23:260.
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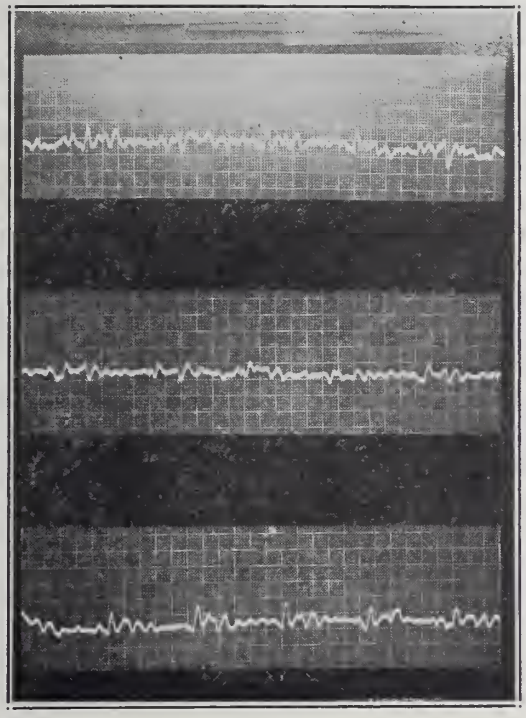


Figure 1.



Figure 3.



Figure 2.

Leriche[4] states that in the early stages, a patient presents one or more of the following:

1. Inability to maintain a stable erect posture.
2. Extreme fatigability of the lower limbs when walking or standing.
3. Generalized atrophy of muscle in both buttocks and lower limbs.
4. A marked pallor of the lower limbs.

To this may be added

5. Coldness of the feet.
6. Intermittent claudication.
7. Later, trophic changes of the skin and gangrene.

The ballistocardiographic patterns have been described by Elkin[6] and by Murphy.[11]

Aortography seems to be the most important procedure in determining the nature of the interference in the circulation. Abdominal aneurysm, coarctation of the aorta and thrombosis of the abdominal aorta can best be differentiated this way. The procedure has previously been well described by Dos Santos in 1931 and others.[12, 13, 14]

11. Murphy, R. A., Jr.: American Heart Journal, 39:174 (1950).
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Freeman[15] describes the procedure of mobilizing the splenic artery after splenectomy and its anastomosis with the patent portion of the aorta below the obstruction.

Deterling[16] reported that dogs sacrificed after three years who had been subjected to homologous arterial grafts either from an arterial bank or a fresh autopsy specimen, showed complete replacement of the normal architecture of the aorta with marked thinning and aneurysmal dilatation. This same end result was observed with autogenous vein grafts.

In view of the extensive involvement of the terminal aorta and internal and external iliac arteries bilaterally, it was decided that a lumbar sympathectomy with the strict adherence to abstinence from smoking, together with meticulous foot care was the procedure of choice. We are aware that some clinics are treating this type of case by thrombo-endarterectomy.

15. Freeman: Personal Communication.
16. Deterling: (At convention of The Society for Vascular Surgery, Chicago (June 1952).

SUMMARY

1. A case of chronic obstruction of the abdominal aorta is presented.
2. The facility with which these cases can be diagnosed is reviewed.
3. Various methods of therapy are discussed and the treatment of choice in this case is described.

121 East Seventh Street

OXYGEN THERAPY FOR BLOOD DONORS

Thomas K. Rathmell,* M.D., Trenton, N. J.

Experienced personnel of any donor center are aware of the physical criteria which should be met by a prospective donor. Even where close checking of donors is followed, it becomes apparent that despite precautions, temporary circulatory and respiratory embarrassment do occur following the collection of a pint of blood. In the past, we have relied upon such aids as elevating legs, inhalation of aromatic spirits of ammonia, artificial respiration, and even re-infusion of the donor's blood.

Since November 1951, this hospital* has had a portable oxygen tank with inhalation mask permanently assigned to our donor room. It is used on any donor who shows loss of palpable wrist pulse, or other signs of severe shock following blood donation. We administer the oxygen at the rate of 10 liters per minute through a rebreathing face mask. This therapy for two minutes, or longer, if indicated, brings about a rapid restoration of the donor's peripheral pulse, color, mental clarity, and a general sense of well being.

To those who are responsible for the safety of the blood donor, and who wish to avoid the shock syndrome noted in occasional donors, we recommend the installation and use of oxygen therapy in their donor areas. It provides a desirable method of combatting the shock syndrome which is frequently encountered following the collection of a pint of blood.

* Pathologist to The Mercer Hospital, Trenton, New Jersey.

CONSERVATISM IN SKIN THERAPY

A NEW COD LIVER OIL LOTION

M. H. HOLLAND, M.D., Weehawken, N. J.

For many years dermatologists have urged caution in the handling of skin eruptions. Most specialists in the care of the skin reflect a trend towards conservatism in dermatologic therapy. This has stimulated a search for a relatively hypoallergenic preparation for widespread topical usage in a variety of cutaneous disorders. This report is a summary of clinical experiences with a bland lotion* containing cod liver oil, incorporated for its well-known healing and soothing properties.

Most doctors are aware of the inherent dangers of topical medications containing skin irritants or sensitizers. Whereas, reactions from mercury, sulfur and iodine were formerly of common occurrence, the past decade has given birth to a newer group of therapeutic agents such as the nitrofurazones, the sulfonamides and the antibiotics which, while very efficacious, are also responsible for many adverse side effects. Of late, the topical anesthetics, notably the "caine" group (benzocaine, Nupercaine† and others), and even more recently the antihistamine salves, creams, and lotions have captured the fancy of the physician who may be called upon to prescribe for an often undiagnosed but persistently itchy skin eruption. These preparations are frequently responsible for cutaneous sensitization. The latter, it should be borne in mind, are not primarily antihistaminic in effect, but as suggested by Lehmann,[1] act more like anesthetics to which they are closely related chemically.

Despite the warning sounded by many authorities in dermatology concerning undesirable side reactions following the application of these agents, this observer continues to see almost daily instances of sensitization dermatitis following the topical use of either the "caine" group of anesthetics or the antihistamines. In consequence, therefore, he would advise those who do prescribe them to do so only with extreme caution. At the very least, patients should be warned to discontinue them if any untoward reaction occurs. Incidentally, lest there be any misunderstanding, reference to the antihistamines is made only with regard to their topical application and not to the systemic form which the writer acknowledges as a most valuable adjuvant when used where properly indicated.

Relief from itching and discomfort of the skin is not a justifiable reason for the use of these topical anesthesia-inducing agents. This claim is refuted by the controlled experiments of Perry,[2] and Baldridge[3] and Shelley and his co-workers.[4] Furthermore, the possible consequences of their use are more than sufficient to interdict their employment. For example, Ellis and Bundick[5] reported adverse clinical reactions in no less than 28 per cent (sic) of patients who had used a much-advertised antihistaminic salve and lotion for an average of fifty days. Further, as Peck[6] pointed out, the possible danger of the development of cross-sensitization and its undesirable sequelae must not be overlooked whenever a chemical or contact-type dermatitis occurs as a result of sensitization.

Cross-sensitization is a phenomenon which denotes the acquisition of sensitization to a substance, not previously the cause of allergic reaction, as the result of sensitization to a different chemical compound. For instance Dobkevitch and Baer[7] reported the development of sensitization to azo dyes encountered in nylon stockings as the result of a previous sensitization to paraphenylenediamine occurring in hair dye.

Sulzberger, Kanof and Baer[10] observed cross-sensitization to paraminobenzoic acid in

*Desitin lotion, kindly supplied by the Desitin Chemical Company, Providence, Rhode Island.

†Nupercaine is the trade-name used by Ciba Pharmaceutical Products, Inc., for their brand of di bucaine.

a number of patients who had dermatitis due to sulfonamide drugs. Philips[11] showed that in patients who had dermatoses from various sulfonamides, there was a high incidence of hypersensitivity to procaine. Peck and Feldman[12] reported a case of sensitivity to sulfathiazole, benzocaine, paraminobenzoic acid, Pontocaine** and Butyn‡ sulfate. Baer and Leider[13] tested twenty subjects known to have allergic contact sensitivity to paraphenylenediamine by feeding them azo dyes certified for use in foods, drugs and cosmetics. In seven, there was an exacerbation of the skin lesions and in five, aggravation of the itching. Peck[6] explains cross-sensitization to such apparently unrelated chemicals as Pyribenzamine‡‡ and sulfapyridine as being due to the common pyridine group in their chemical structure.

Numerous similar instances of cross-sensitization reactions have also been observed by the writer. For example:

1. A local doctor who developed skin sensitization to procaine, later suffered from an eruption due to the resin finish in shorts material and still later acquired a severe cutaneous sensitization to penicillin.
2. A fifty-two year old housewife developed a maculo-papular eruption, due to Pyribenzamine‡‡ which was taken by mouth for an eruption due to sulfonamides.
3. In a forty-nine year old woman, dermatitis of the legs, incurred as the result of sensitization to the azo dye in her nylon stockings, was followed by a papular eruption due to Pyribenzamine‡‡ prescribed for the itching. Six weeks later, following the ingestion of triple sulfonamides taken for an upper respiratory infection, she developed a severe generalized erythroderma.

Lane[14] in a recent paper on what he so aptly calls "Therapeutic Dermatitis", (which was made the subject of an editorial in the July issue of this Journal), presents convincing evidence in favor of conservative dermatologic therapy. He cited numerous instances of dermatitis resulting from contact with topical anesthetics, (about 41 proprietary preparations containing topical anesthetics are listed). He also mentions many other potentially dangerous chemicals commonly applied to the much-abused human integument with undesirable consequences.

** Pontocaine is the Winthrop-Stearns trade-name for a brand of tetracaine.
‡ Butyn is the Abbott Laboratories trade-name for a brand of bucaine.
‡‡ Pyribenzamine is the trade-name for a brand of dimethyl benzyl ethylene diamine prepared by Ciba Pharmaceutical Products, Inc.

One can only imagine what an accumulation of untoward skin reactions Pillsbury[15] must have experienced to prompt him to state in a recent article that "the production of epidermal sensitization by the application of various chemicals in treatment is probably the single most important source of present-day dermatologic disability".

In view of the foregoing, this report presents a clinical trial of a smooth, homogeneous, gritless and free flowing lotion[16] containing only the blandest of ingredients (zinc oxide, magnesium carbonate, rose and lime water) in combination with cod liver oil.

This lotion was employed in the treatment of one hundred cases of various types of inflammatory dermatitis. In no case was there a single instance of true skin sensitization despite prolonged use. Furthermore, in almost every patient, the dermatitis was either relieved, improved, or completely resolved following the use of this lotion alone or in conjunction with other conservative measures such as wet compresses with diluted Burow's solution, potassium permanganate (1 to 6,000) et cetera.

These results speak for themselves and should serve as an outstanding testimonial in favor of conservatism in skin therapy. Those who originated the formula for the lotion tested must surely have had in mind the venerable adage—unhappily, too often ignored—"Primum nihil nocere", the adherence to which the writer has observed for many years with gratifying results, not to say grateful patients.

Disorder treated with cod liver oil lotion	Improved	Greatly Improved	Entirely Cleared	Aggravated
Dermatitis venenata	0	3	22	0
Contact eczema	2	2	10	2
Pityriasis rosea	0	0	6	0
Pityriasis rosea (uncomplicated)	0	0	5	0
Intertrigo	2	2	6	0
Lichen planus	3	0	0	0
Hemostatic eczema	3	7	0	0
Pemphigus vulgaris	0	0	0	1
Exudative eczema	3	5	2	0
Dermatitis medicamentosa	1	0	4	0
Dermatitis axillae	0	0	3	0
Atopic dermatitis	2	6	0	0

SUMMARY

1. Note is made of the frequent pleas by dermatologists in favor of bland therapy in the treatment of skin diseases.

2. The dangers inherent in the use of topical medicaments as the result of sensitization is discussed and the more common offenders listed.

3. The further complication resulting from cross-sensitization following dermatitis of the contact type is stressed and some examples cited.

4. The success obtained and the freedom from untoward reaction following the use of a soothing lotion[16] containing cod liver oil is recorded and considered a potent argument in favor of conservatism in dermatologic therapy.

2412 Palisade Avenue

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16. Desitin lotion, kindly supplied by the Desitin Chemical Company.

TUBERCULOSIS CHEMOTHERAPY SEMINAR

The New Jersey Chapter, American College of Chest Physicians announce a joint meeting with the Tri-Hospital Clinical Society of Elizabeth, to be held at Bonnie Burn Sanatorium, Scotch Plains, N. J., on Tuesday, November 18, 1952 at 8:30 p.m. The program follows:

1. Concepts in the Use of Streptomycin and Para-amino-salicylic Acid. By Dr. Julia Jones, Assistant Professor of Medicine, College of Physicians and Surgeons, Columbia University.

2. Latest Observations in the Treatment of Tuberculosis with Hydrazide of Nicotinic Acid. By Dr. Edward H. Robitzek, Acting Director of Medicine, Seaview Hospital, Staten Island. Paper will be discussed by Dr. Joseph A. Smith, Medical Director, New Jersey State Sanatorium, Glen Gardner, New Jersey.

3. Pathologic Changes Following Use of Chemotherapy in Tuberculosis, by Dr. Oscar Averbach, Director, Laboratory Service, Veterans Administration Hospital, East Orange, N. J. Discussion will be opened by Sylvan Moolten, Ch.P., Pathologist, Roosevelt Hospital for Chest Diseases at Metuchen, New Jersey.

Collation will follow. All physicians are welcome to attend.

GENERAL PRACTICE SESSION: DECEMBER 13

The New Jersey Academy of General Practice announces a scientific session on Saturday afternoon, December 13, 1952, at the Essex House, Lincoln Park at Broad Street, in Newark. The symposium will concentrate on the problem of hypertension. The program starts at 1 p.m. Speakers and topics follow:

Cause and Diagnosis of Hypertension—A. C. Corcoran, M. D., Cleveland, Ohio.

Predisposing Causes of Hypertension and its Complications—K. L. Pines, M.D., New York.

Psychosomatic Aspects of Hypertension—Melvin Thorner, M. D., Philadelphia.

Diagnosis of Hypertension—Charles Poindexter, M.D., New York.

The Treatment of Hypertension—Robert S. Palmer, M.D., Boston.

For further information, write to Dr. Aaron H. Horland at 129 Chancellor Avenue, Newark 8, N. J.

RECOGNITION AND MANAGEMENT OF SYMPTOMS ASSOCIATED WITH DEPRESSIVE STATES

Samuel A. Sandler, M.D., Hackensack, N. J.

Every general practitioner has his quota of obvious neurotic depressions. However, depresion may hide beneath the disguise of physical complaints. These patients may complain of weakness, insomnia, vague head discomforts, cardiac complaints, or symptoms referable to the abdomen, back, or extremities. Others may present such complaints as: generalized weakness, loss of weight, constipation, and a decline of potency and libido.

The patient with frank depression enters the office slowly, as if it was a great effort to move his extremities. He complains that he is always tired, he has lost interest in his work, his family, the ordinary affairs of living, that he no longer enjoys television, has lost interest in the radio and newspapers, doesn't care to visit or have visitors. He seems sad and tense. As you listen to his story, he may break into tears. He tells you that he cannot concentrate, that he cannot plan for the day, that he has no desire to get out of bed in the morning. He insists that he gets little or no sleep at night, has no desire for food, that his bowels have not moved for days.

A patient with a depression on a deeper level, upon questioning, soon reveals that he feels hopeless, that there is no future for him, that everything in his environment is dark and dismal. He insists that his self-confidence is destroyed and that his family will soon be ruined because of his shortcomings and failure. His speech and thinking take on the quality of great effort. There is an undertone that the world is against him and it means to destroy him. He insists that he is a dismal failure and unworthy to receive help. Questioning reveals that he has ideas of self-destruction and has strong impulses in that direction.

In organic depressions or involutional types, the patient develops a tremendous feeling of guilt. He feels that he has ruined his family. He may have delusions referable to three general spheres: those connected with religion and sin; delusions referable to some malignant disease; or delusions referable to loss of wealth and ensuing poverty.

A depression may come on acutely as a reaction to a situation or it may develop insidiously. The depression which comes on acutely, may resemble in a crude way, the balloon which is suddenly pricked, then bursts. Thus, the individual in an acute depression may feel deflated and totally crushed. Another crude analogy is that it is as if someone suddenly jammed the brakes in a moving car. The car comes to a dead stop, though the motor is still functioning. Yet, for practical purposes, nothing seems to move. So it is with the patient, he is alive, but has no capacity for living.

Depression may be characterized, in my opinion, symbolically by a situation in which the patient says "no" to the three important L's—life, labor, and love. He is living in a state of emotional vacuity!

For a long time it was thought that depressions were found only in "inferior" individuals or people of a certain constitutional type. This is not true. Some very capable and brilliant people have had depressions. Lincoln had a depression at one time which lasted a year. James Forrestal, who had the third highest position in the United States Government, not only had a depression, but destroyed himself. It is to be remembered that this man was successful in business, politics and in every activity in which he participated. Those who are most subject to a depression, are moody individuals, neurotics, schizophrenics, general paretics, involutional cases, and persons with organic cerebral disease.

Depressions are the result of a combination of factors, such as, constitutional tendencies, physiologic changes, bio-physical changes, bio-

chemical reactions, psychologic and environmental causes. Psychologically, depressions are an attempt on part of the patient unconsciously to force love and care from someone he greatly loves and whom he feels he has lost. A neurotic individual feels depressed because he is certain that he is no longer loved; a feeling which is not generally in keeping with the real situation. Depression is an unconscious attempt to manipulate the disappointing "love object" into a situation where he or she will gratify the individual's craving for affection as it was done in his earlier life by his mother, sister, father, or some other loved object. The depressed patient struggles against the notion that he is no longer cared for, needed, wanted, or esteemed. Without this feeling of self-esteem, life becomes difficult and at times impossible for the depressed individuals.

The dynamics of depressions were most effectively worked out by three psychiatrists: Freud[1] in 1917, Abraham[2] in 1924, and Rado[3] in 1927. Rado[4] later pointed out that a depressive spell is composed of three primary constituents—the alteration of mood to one of sustained gloomy repentance, the regressive yearning for the elementary security of the infant, and the struggle between the excessive emergent emotions in which submissive fear defeats coercive rage. The depressed individual is caught on a see-saw. On one side are feelings of resentment and rage against the object which he feels injured him; on the other side he feels guilty and repentant at having destructive and hostile feelings against a loved person. These feelings are thrown backwards and forwards until the individual becomes confused and distraught. It is as if he were caught in the midst of a chemical reaction with strong forces going to the positive pole and other electrolytes going to the negative pole, pulling him hither and yon. There is no peace, no contentment, no resolution. An emotional ferment is going on all the time.

Representative Case Histories

A CASE OF SIMPLE DEPRESSION

A fifty-nine year old pharmacist complained that his present illness began a year ago with a gastrointestinal discomfort. Shortly thereafter it was discovered that he was suffering from diverticulosis. About the same time he became very nervous and depressed. He had a difficult and strenuous winter, working very hard. When the slack season came along in the spring, he had idle time and he found it difficult to occupy himself. He became very irritable and fretful. He went on a summer vacation but could not enjoy himself, nor get any peace or comfort.

At the time of his first examination, he complained that he had no drive, no pleasure in anything, and he had no desire to work. He just wanted to "sit and sit". He had difficulty in sleeping. He could not fall asleep until late in the morning. After going to bed he tossed restlessly. Upon arising he had no desire to get up or go out to see anyone. He formerly was sociable and liked to be with people, according to his wife. She stated, "He was the life of the party, but now he wants to be alone". He was formerly an enthusiastic individual, full of enthusiasm about his church. Now he has dropped it completely. He resented his wife's leaving him to take care of a seriously ill sister. He felt his wife was deserting him, although, intellectually, he knew that he was wrong. He lost confidence in his ability as a druggist and did not feel that he could carry on his job. He felt trapped. He lost incentive and initiative. He was greatly worried about his future. He was given psychotherapy for several months with excellent results.

He was not seen again until ten months later when he complained that he was depressed again. He stated that he had to drag himself to work, that he felt constantly exhausted, that he was worried as to whether he could hold on to his job. He could give no reason for these feelings. On questioning however, it developed that the boss had hired a younger man who was more "up-to-date" and better trained and who (he thought) was being favored by his boss. He felt insecure and threatened in his job. He was given psychotherapy over a period of a month with good results.

A CASE OF REACTIVE DEPRESSION

This housewife is twenty-seven years old, has been married for eight years and has two children—one seven years and the other nine months of age. Her present illness began about eight months ago after she was taken home from the local hospital following the delivery of her youngest child. Her father had driven her home from the hospital. A few hours after her arrival home, she went into her father's room with her baby to show him what a fine grandchild he had and found that he was dead. This was a great shock as she was greatly attached to him and thought he was perfectly well before she entered the room. She developed a guilt feeling stating that he must have been ill when he called for her and that she permitted him to drive her home when he must have been seriously sick. She felt she had imposed upon him; that he was probably in the middle of a heart attack when he was driving her home earlier in the day, but said nothing to

1. Freud, Sigmund: "Mourning and Melancholia". In *Collected Papers*, 4:152. London, Edward Arnold (1925).
2. Abraham, K.: *Selected Papers*. p. 418. London, 1927. Hogarth Press.
3. Rado, Sandor: *The Problem of Melancholia*. International Journal of PsychoAnalysis, 9:420 (June 1928).
4. Rado, Sandor: Psychosomatic Medicine, 13:51 (February 1951).

her. She felt lost and hopeless. She said, "Things are in such a way, I don't know what to do or how to get a hold of myself". She lost considerable weight and suffers from anorexia. Her housework and everything else has become an effort. She has no desire to shop or socialize. She has no sexual desires. She always feels exhausted.

She has generalized aches and pains. She has "pressure pains" across her forehead. She suffers from insomnia, and nocturnal restlessness. She cries a great deal, and has spells of tremulousness. In addition to her own immediate difficulties, she states that her 7-year old son is a "devil" who keeps her upset all day long; that the youngster is hard to manage; that he is disobedient and willful. Another complication is that the patient's mother, who lives in the same house, is constantly interfering in the management of her (the patient's) home with the result that the patient has lost confidence in her ability to manage her own home and affairs.

A CASE OF DEPRESSIVE SCHIZOPHRENIA

This 21-year old student nurse was seen at home. Her parents said that she had a slight "concussion" about seven weeks ago which seemed to be of minor consequences. Because of her constant complaints of headache and bouts of screaming with pain, she was observed in the hospital for several weeks. Because no diagnosis could be made, she was sent to the New York Neurologic Institute where she was observed for three weeks more. No organic findings were noted. Two weeks later, she returned to training, but still complained about her headaches. She began to scream with pain. My impression was that we were dealing with hysterical and depressive symptoms in a schizophrenic youngster. I recommended electroshock treatments. About a half dozen treatments were given with recovery.

The latest reports I received are that the girl has gone back to work and is finishing her course. Within two months of graduation, she developed an obsession that she was failing and would be denied her diploma. She was found on the floor in stupor and a tentative diagnosis of possible subdural hematoma was made, by the hospital staff, with no clinical confirmation.

AGITATED DEPRESSION WITH PARANOID FEATURES

This is a 58-year old housewife, married for thirty-seven years, and has four grown up children. A few months ago, she had an attack of dyspnea following a scuffle with her husband. These attacks of dyspnea have been frequent, usually after she sees her husband. The dyspneic attacks have been associated with inability to sleep nights and are accompanied by anxiety and terror. She has not eaten food for the past several days and when she attempts to do so she insists the food hurts her throat. She has a constant desire "to scream and jump out of my skin". She is agitated and will walk the floor most of the night until she exhausts herself.

When the patient herself was questioned, she gave the following story: she felt that something dreadful would happen. She is unable to explain what. She feels she wants to be away from everything and everybody but cannot stand being alone. She feels she cannot "take any more abuse". She is frightened by the nights. She cannot sit still. She does not have anything to interest her and feels that people are talking about her.

The core of her difficulties centers around her husband, who was a prosperous manufacturer, but deserted her and is now living with another woman.

The patient made a complete recovery with electroshock treatments and psychotherapy.

A CASE OF REACTIVE DEPRESSION

A fifty-one year old truck transportation salesman, married twenty-two years, (has no children) stated that on New Year's Day, 1952, he was injured while driving with his wife and niece. They were sitting in the car when they were struck from behind. He says he received no lacerations or fractures, but was "badly shaken up". He was observed for a few hours at a hospital and then discharged. He complained of a severe, lancinating headache which radiates around the top of the calvarium and lasts for about ten minutes. In addition, he is greatly depressed. He has lost all interest in his work, his family, his friends, and all outside activities. He suffers from insomnia. He has lost sixty pounds in the past year, most of this within the last three months. He has strong impulses to destroy himself. Last November, a very dear friend committed suicide. He was seen only once in consultation. The family was advised to institutionalize this man because of his strong self-destructive impulses.

DEPRESSION WITH ORGANIC DISEASE

This is a forty-two year old research consultant in insurance. He has been married for nineteen years. He was first seen because of jacksonian convulsive movements in the left upper and left lower extremities. At that time a diagnosis of brain tumor was made and the patient was operated on shortly thereafter. The pathologist reported an astrocytoma. The lesion was not entirely resected because of its infiltrating character; to do so would have left the man hemiplegic. He was given a course of deep x-ray treatments with good results.

I did not see this man again until three and one-half years later when I was requested to examine him by his family physician. The patient said that since his operation, things have been going badly. He has been reduced from a "consultant" to a "high class filing clerk". He has had difficulty in remembering procedures in his office and outside of his office that he had been performing successfully for over twenty years. He cannot make decisions. He has difficulty even in deciding what clothes to wear. He is depressed and has suicidal ideas. He has been having domestic difficulties He has lost all emotional interest in his wife. He always had a feeling of tension and critical attitude towards his wife but this became worse since his brain operation. He recently has become extremely irritable towards everything and everyone. He explains that formerly he was a "happy-go-lucky" type of individual; but now he is a "sour puss". He has lost all his initiative and ambition. He used to have many friends and enjoy their company. Now he has no interest in seeing anyone except a certain lady friend. He

has a son in the military service in Korea. When I discussed his son with the patient, he showed no anxiety concerning him. He replied, "Oh maybe some day he will stop a bullet, but he can take care of himself". This was said with no emotion and in a rather flippant manner. He added that his efficieney in the office has become extremely low, that his former duties were taken away from him and now, "I am sort of pushed into the corner". Here we have a depression as a result of mental deterioration in a patient with a brain tumor.

A CASE OF INVOLUTIONAL MELANCHOLIA

The patient has been married for the past thirty-four years and is fifty-eight years of age. This is his second marriage. He was divorced from his first wife. He was employed for years as a steward in a social club. Has always been a "high-strung", alert individual. At present he has confined himself to his home for a number of months. For the past four years, his wife points out that they have been very close, in fact, "too close". Last August the patient's wife developed a "nervous condition" and the patient became very disturbed about her. He was afraid that she was going to die. He began to show changes in personality. Although he was a meticulous dresser before, now he would not shave, would not dress and was occupied only with ideas about his wife's health. He insisted that she was dangerously ill and he did not want her to go out or do anything. His wife, on the contrary, insisted that she was improving in her health. He became dissatisfied with everything. He began to smell "burning metals" throughout the house. He had all the plumbers and furnace people in the community looking at his oil burner to make sure that there was nothing wrong with it. After each examination, each mechanic would insist that there was nothing wrong with the heating mechanism but he would not be satisfied. He wanted to have all the pipes in the house torn out. The problem of heating and the furnace and the possible burning of his home became an obsession. He insisted the flames were coming through the pipes, that he could taste the smell of fire and he told his wife that he was being asphyxiated by the furnace. He insisted every day that the house was going to blow up. He took his valuable papers, jewelry and monies, put them in a tin box near the door, "so when the house would blow up, I could get out quickly".

He had lived in this house for over twenty years and had kept improving it. The house had always been comfortable before. He insisted that it was now unliveable. He would not sleep upstairs, because he wanted to be near the door when the great tragedy occurred. He would walk the floor all night. Had a ravenous appetite. He cried intermittently and copiously because of the delusional forthcoming tragedy. He became untidy, slovenly and dirty. He tried to pull his teeth out. He was unable to listen to the radio or television or even read because his mind kept constantly reverting to the impending holocaust. He locked his car in the garage and refused to use it for months because he stated that he could smell things burning in the car. His wife insisted that there was nothing wrong with the car. He complained that he heard noises of all the gadgets and machines and other appliances that function in the house, running through his head.

This man was given a course of ten electroshock treatments with complete recovery. When last seen about a month later, he was getting ready to go back to work.

TREATMENT OF DEPRESSIONS[5]

Every depressed patient is a potential suicide; therefore, it is necessary to think constantly about the preservation of the patient's life. It is not always easy to tell which patient has definitely decided to destroy himself. Frequently when such a decision is reached, the patient may deceive us by his good humor. On occasion he will even tell jokes, and shortly thereafter, we learn that he has killed himself. His joke-telling was simply the relief and happiness in the feeling that he has definitely made the decision to solve his problem, for once and for all, by suicide. Here are some of the danger signals: when a patient points out his extreme hopelessness, his worthlessness and futility of all his endeavors, this is the time to become concerned. A family history of suicides is an especially dangerous situation. It represents a sort of hypnotic attraction for the patient—to repeat a previous family member's act of self-destruction. Such a patient may feel that it is his "destiny" to commit suicide. He then compulsively and obsessively goes about consummating this drive. Any doctor who treats depressions that have any depth or intensity, must warn the family of this danger and be sure that razor blades, poisons, and dangerous drugs are removed from the medicine chest or the household.

In simple depressions, psychotherapy can accomplish the recovery of the patient, assisted by sedation, physical therapy, occupational therapy, and "tonics". It is a good idea to give the patient, losing weight, some milk and crackers about ten o'clock in the morning and an egg nog or malted milk at three in the afternoon. A glass of warm milk or similar nutrient at night before retiring will also help. It is not wise, for the unskilled, to be too analytical or to bring out the hostilities or the guilt feelings in a patient because this may cause him to become panicky and even light the spark that

5. Diethelm, Oskar: *Treatment in Psychiatry*. New York 1936. Macmillan.

will end in suicide. In severe depressions, such as involutional melancholia, or schizophrenia, electroshock will often be very helpful. In involutional melancholia, about 85 per cent of the patients will recover within three weeks with electroshock therapy.

Sexual activities should be discouraged as they often are attempts by the patient to prove his potency. Usually these ambitions are unsuccessful with the result that the patient feels worse after his failure than he did before. It is unwise to let the patient who complains of being tired or exhausted rest in bed either in the morning or the afternoon because the minds of these patients are very active while they are resting. When they arise in the morning they are more disturbed emotionally than on the previous evening. Alcohol is a dangerous remedy as it is easy for a depressed patient to form a permanent habit of depending on alcohol and before long we have two diseases—a depression and a chronic alcoholic.

For sedation, paraldehyde, 3 to 6 cubic centimeters, given in cracked ice and fruit juices, as needed is very effective. A safe sedative is barbital, 10 grains (0.6 Grams) with hot milk at night. Nearly all depressed patients suffer from constipation and it may be necessary for the physician to remove impacted feces by hand. When consummated, this makes the patient very grateful. One may give rectal instillations of cotton seed or olive oil at night. This has a soothing effect on the spastic colon and frequently this is a very helpful procedure. Because every depressed patient loses weight, he should be put on a high caloric diet.

The physician must not be too free with sedatives or other drugs because he may be introducing a factor of toxicity which may only complicate an already difficult disease. Psychotherapy should be constantly applied; the patient should be encouraged to do everything that will raise his self-esteem. He must be urged to write to his friends; make new acquaintances, participate in social activities, and push himself into the stream of life. These patients need the doctor's time; and they are worthy of it, for this may be the instrument of saving a life. The doctor who is too busy to give these patients unhurried and sympathetic attention had best refer them to those who can meet the challenge.

254 Union Street

SHIPBOARD MEDICAL ASSEMBLY

A unique opportunity to combine graduate education with a sea voyage is now offered by the Pan-American Medical Association. The Association has chartered the Holland-American liner "Nieuw Amsterdam" which will sail from New York on January 7, 1953. Scientific sessions of the Congress will be held each morning while the ship is at sea.

Registration fee is only $25.00 per passenger plus the cost of the accommodation. The ship will return to New York on the afternoon of Monday, January 19. Accommodations vary from $300.00 up. Stateroom plans, schedules and additional information may be obtained from Dr. Joseph J. Eller, 755 Fifth Avenue, New York 22, N. Y.

OBSTETRICS AND GYNECOLOGY SESSION

The American Academy of Obstetrics and Gynecology announces a clinical session at the Palmer House in Chicago, December 15 to 17, 1952.

An extensive scientific program has been scheduled covering all aspects of both specialties. For further information communicate with the Academy at 116 South Michigan Avenue, Chicago 3, Illinois.

PSEUDOCYSTS OF THE LUNG

EDWARD LEVITZKY, M.D.; ATHUR HEYMAN, M.D.; and
J. H. BROMBERG, M.D.,* Newark, N. J.

The first case report of cystic disease of the lung in the American literature was made by Koontz[1] in 1925. He also reviewed 108 cases in the foreign literature. The many cases reported since then suggest that lung cysts are not uncommon. However, Caffey's recent studies[2, 3, 4] point up the rarity of true lung cysts. He has collected a significantly large series of cases in infants and children whose lung x-rays revealed cystic areas which resolved spontaneously. Caffey designates these as intrapulmonary emphysematous cavities and believes that similar pictures reported by various authors[5, 6] as pseudocysts or pneumatoceles are common, but that true congenital cysts are rarely found. Therefore, conservative treatment is indicated in most cases.

Two cases of pseudocysts of the lungs were observed on the Pediatric Service of the Newark Beth Israel Hospital and are reported below:



Figure 1—Case 1. AP Chest. 3/6/51. Note two cyst-like radiolucent shadows in right lower lobe base medially.



Figure 2—Case 1. Lateral Chest. 3/6/51. Lateral view showing radiolucent shadow posteriorly at right lower lobe base.

CASE ONE

This two pound four ounce premature infant was delivered normally at the Newark Beth Israel Hospital on January 26, 1951 after twenty-six weeks' gestation. Physical examination upon transfer to the premature unit was normal. Feedings were started by gavage on the third day. Progress was good for three weeks; then respiratory distress with substernal retraction and rapid respiration was noted. Physical examination was unrevealing, and the episode passed quickly. Two weeks later the infant showed a temperature rise, supra- and infrasternal retractions, labored and rapid respirations. Examination of the chest showed dullness and depressed breath sounds at the right axilla and base. Administration of antibiotics was begun. Chest x-rays at this time showed two radiolucent shadows about 2 centimeters in diameter above the right hemidiaphragm posteriorly. Lipiodol studies showed these areas as separate from the gastro-

*From the Pediatric and X-Ray Services, Newark Beth Israel Hospital and the Newark Clinical Group.

1. Koontz, A. R.: Congenital Cysts of the Lung. Bull. Johns Hopkins Hosp., 37:340 (1925).
2. Caffey, J.: Regional Obstructive Pulmonary Emphysema in Infants and Children. Am. J. Dis. Child., 60:586 (1940).
3. Caffey, J.: Pediatric X-ray Diagnosis. Chicago, The Year Book Publishers, Inc. (1950).
4. Caffey, J.: Benign Pulmonary Cavitation of the Lungs and Congenital Cystic Disease. Lecture, Eastern Conference of Radiologists. New York, N. Y. (March 1952).
5. Potts, W. J., and Riker, W. L.: Differentiation of Congenital Cysts of the Lung, and Those Following Staphylococcic Pneumonia. Arch. Surg., 61:684 (October 1950).
6. Murphy, J. D., and Piver, J. D.: Cystic Disease of the Lung. Dis. of Chest, 19:454 (April 1951).

intestinal tract. Two days later, the infant appeared perfectly normal, and examination of the chest was essentially negative. Hospital course was uneventful until March 28, a three week interval, when there was another episode of respiratory distress. Antibiotics were again started and the disturbances subsided in three days. Examination showed slight increase in size of the cysts on March 30, 1951, and complete disappearance on April 13, 1951, three months after their first appearance. The rest of the hospital course was uneventful and the baby was discharged on May 10, 1951, with a weight of seven pounds. Since that time serial x-rays have failed to show a recurrence of the condition. The infant is now one year old and is apparently well and normal.



Figure 3—Case 1. AP Chest. 6/1/51. Chest is normal. Pseudocysts have disappeared completely.

CASE TWO

This four pound premature infant was born at the Beth Israel Hospital on October 15, 1951 after thirty-four weeks' gestation. Delivery was by low forceps. Physical examination upon transfer to the premature unit was essentially negative. The course was uneventful until October 29, when the patient, then two weeks old, had a temperature rise to 101. Respirations were difficult, with infrasternal retractions. Crepitant rales were heard in the right axilla.

Roentgenograms taken on October 29, 1951 showed several areas of consolidation in both central lung fields which extended to the periphery. The infant was given antibiotics and the episode passed over after several days. X-rays taken seven days later showed partial resolution of the consolidated areas and evidence of a fibro-cystic alteration of the lung tissue. Subsequent x-rays showed changes in number and size of the cysts. There were no further disturbances, and the baby was discharged on November 29, 1951, aged 45 days, weighing six pounds one ounce, and physically normal.

A roentgenogram taken on March 19, 1952 (five months later) showed disappearance of all but one



Figure 4—Case 2. AP Chest. 10/29/51. Note bilateral pneumonia.



Figure 5—Case 2. Lateral Chest. 10/29/51. Lateral view showing extensive pneumonia.

cyst. This also cleared by June 5, 1952, and x-ray of the chest at that time was normal. The infant has been clinically well.

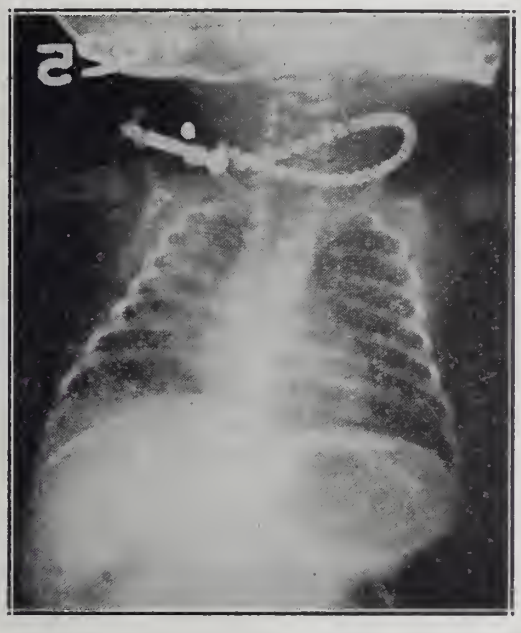


Figure 6—Case 2. AP Chest. 11/23/51. Note multiple small round radiolucent cyst-like shadows right lower lung field, and larger radiolucent shadows, partially obscured by heart, in left lower lung field medially.

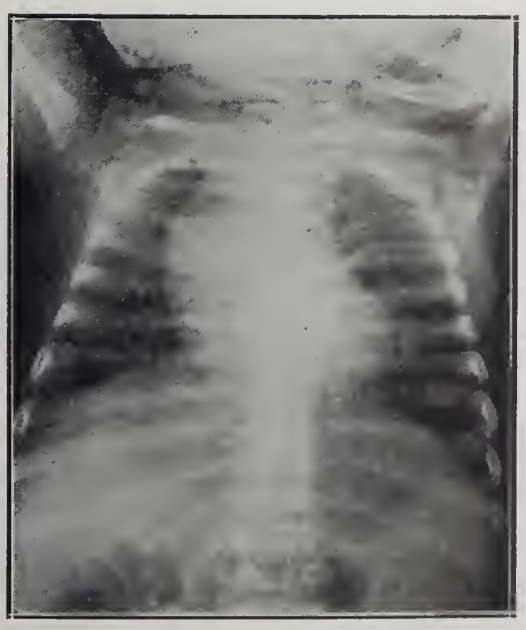


Figure 7—Case 2. AP Chest. 3/19/52. Pseudocysts have disappeared from right lung. Note only single pseudocyst in left lower lung field.



Figure 8—Case 2. AP Chest. 6/5/52. Lungs clear. All pseudocysts have disappeared. Thymus causes superior mediastinal widening, and is not abnormal at this age.

Our two cases present characteristic pictures. A normal infant contracts a respiratory infection with the acute stage made minimal by the use of antibiotics. X-rays in the convalescent stage show cyst-like cavities, which disappear spontaneously with the passage of time and conservative management. Certainly these are not true congenital cysts when viewed in retrospect. The original roentgenologic picture did not differentiate the two conditions.

We turn now to the probable etiology of these pseudocysts or emphysematous cavities. A respiratory infection results in the production of inflammatory exudate. The exudate acts as a check valve obstruction of a bronchus, permitting air to enter during inspiration but preventing its escape during expiration. The result is a cumulative alveolar distention in the segment of the lung distal to the obstruction and the formation of a pseudocyst. With the clearing of the obstructing exudate, the check valve mechanism disappears and the pseudocyst goes on to closure.

Pathologically, the pseudocyst is a non-epithelialized, positive pressure cavity containing air and lined by matted alveolar walls. This

is opposed to the true congenital cyst, which is usually epithelial lined and may contain mucoid fluid, pus, air or desquamated debris.

The clinical picture of pseudocysts of the lung is variable. Dyspnea and cyanosis are the most common symptoms; however, if the cysts no longer communicate with a bronchus and secondary infection is not present, they may produce no symptoms. Complications may include pressure atelectasis of surrounding lung tissue, spontaneous pneumothorax, resulting from the rupture of a pseudocyst into the pleural space, or secondary infection. Diagnosis must depend upon roentgenological demonstration. Bronchoscopy and bronchography may be helpful to establish the diagnosis.

Differential diagnosis of pseudocysts of the lungs includes the following:

1. *True congenital pulmonary cysts* — These are rare and do not resolve spontaneously.

2. *Cystic bronchiectasis* — This is due to dilatation of the bronchi as demonstrated by lipiodol studies.

3. *Acquired intrapulmonary cavities* — These are produced by the destruction of pulmonary tissue and are usually characterized by a febrile course, skin sensitivity to tuberculin or fungus material, and sputum positive for the infecting organisms.

4. *Diaphragmatic hernia* — X-ray studies with a contrast medium will demonstrate this anomaly.

The progress of pseudocysts depends upon pressure effects and the occurrence of complications. If a large expanding cavity is present, emergency aspiration of air or even surgical excision may be needed to permit the patient to survive. Fortunately, these cases appear to be the exception.

With the judicious use of antibiotics for control of secondary infection, most cases can be followed conservatively, and spontaneous recovery may occur as in our two cases and those collected by Caffey.[4] The pseudocysts may resolve very slowly and require as long as one and one-half years to disappear completely. Patient observation should be carried out unless pressure symptoms dictate interference.

SUMMARY

Two cases of pseudocysts of the lung in premature infants are presented. Conservative treatment and judicious use of antibiotics was followed by spontaneous disappearance of all cavitations in both cases.

89 Lincoln Park

PRIZE FOR ORTHOPEDIC PAPER

The New Jersey Orthopaedic Society offers to any intern or resident in a New Jersey hospital a prize of $100. for the best original contribution on a subject of interest in the field of orthopedic surgery. It may cover any facet of the field: pathogenesis, pathology, diagnosis, treatment, history, epidemiology, prophylaxis or symptomatology. Manuscripts must be submitted before January 15, 1953. This work must be done during, or not more than six months after termination of the internship or residency. Communicate with the secretary of the society, Dr. William Kruger, at 31 Lincoln Park, Newark 2, N. J. Winner of 1952 Award was Dr. Robert Brendze of the Jersey City Medical Center.

PROCTOLOGY AWARD

The International Academy of Proctology announces that the best unpublished contribution on proctology or allied subjects will be awarded $100 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit. The competition is open to all physicians.

The Academy reserves the exclusive right to publish all contributions in *The American Journal of Proctology and Gastro-enterology.*

Entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. Entries must be sent no later than April 1, 1953 to the International Academy of Proctology, 43-55 Kissena Blvd., Flushing 55, New York.

MEASLES MODIFICATION

THE RATIONAL EMPLOYMENT OF IMMUNE SERUM GLOBULIN

GEORGE HELLER, M.D., Englewood, N. J.

It is generally accepted that gamma globulin (the active principle present in "immune serum globulin" obtained from pooled adult blood) is effective in the lessening of the severity of measles. There is, however, some question concerning the wisdom with which it is being used, especially in cases in which exposure has been minimal or doubtful. It is important that waste be avoided, especially with new vistas appearing which may make this substance a truly scarce material.[1] It is also unwise to use it in such a way that measles, during the age of choice (from four to seven years), be entirely prevented, thereby making the child more liable to infection during later life when the disease is often much more severe, and social and economic conditions make it more disadvantageous.

With these thoughts in mind, during the years 1950, 1951 and 1952, the parent of each child, to whom immune serum was given, was asked to fill in a brief postal card questionnaire to be mailed three weeks following injection. In all, 333 injections were made during this time; 215 cards were returned. Results of this questionnaire are displayed in the tables.

TABLE I

134 HOME (SIBLING) EXPOSURES

Age	No Disease	Mild	Unmodified
0 - 1 yr.	10	2	0
1 - 2	8	12	0
2 - 3	2	16	1
3 - 4	2	24	1
4 - 5	3	22	1
5 - 6	1	6	0
6 - 7	2	3	1
7 yrs. + ...	5	11	1
Total	33 (25%)	96 (72%)	5 (3% +)
(Over 1 yr.) ..	(19%)	(77%)	(4%)

TABLE II

81 PLAY AND SCHOOL CONTACTS

Age	No Disease	Mild	Unmodified
0 - 1 yr.	8	0	0
1 - 2	12	3	0
2 - 3	12	1	0
3 - 4	12	5	0
4 - 5	13	2	0
5 - 6	3	1	0
6 - 7	3	1	0
7 yrs. + ...	3	2	0
Total	66 (81%)	15 (19%)	0 (0%)

The dosage of immune globulin during these years was rather uniform, adhering to the following principles when feasible.

1. Infants under 1 year of age have been given about three times the recommended modifying dose of 0.02 cubic centimeter per pound of body weight.
2. From 1 to 2 years of age, about 0.03 cubic centimeter per pound of body weight.
3. In spite of the known lack of susceptibility among infants under six months of age I *have* advised injection. The procedure is harmless, as far as we know; the required amount of serum is small; and a single case of measles in this age group, (possible if the mother had transmitted no immune bodies), could be disastrous.
4. All other contacts have been given 0.02 cubic centimeter per pound of body weight.
5. I have tried to avoid injection in the case of school exposure only. I have become skeptical about it in children exposed through outdoor play only. Even in cases reporting indoor play immediately prior to the febrile stage, I am reluctant to give the serum.
6. Modification is best achieved by injection of immune serum globulin when the rash appears on the sick contact, roughly four days after exposure. I do not feel that immediate prophylaxis on exposure is advisable. Occasionally, the period of incubation of modified measles is prolonged to as much as three weeks, but this is rare. In general, the incubation period in this study has been equal to that in the unmodified disease.

No complication was reported in any case of modified measles. The complications in the unmodified series (404 cases) during these years comprised only 12 cases of otitis media, which responded promptly to penicillin, and two cases of broncho-pneumonia, both of which were brief and without sequela.

Encephalitis was not a complication of any case in this series, either modified or unmodified. Some authorities say that modification makes this complication less likely, but does not necessarily prevent it. However, the attack rate is so low, even in the full blown disease, that statistics are unreliable.

1. Immune serum globulin retails today at over $5 per 2 cubic centimeters. We are prone to misuse it because it is distributed without charge by the American Red Cross. It must be remembered that this "free" material represents a very real cost factor, and were volunteer donors not forthcoming the cost would exceed the current over-the-counter price.

If the figures in Table II were broken down further, it would be shown that, in large part, those exposed during school hours, or during outdoor play only, are *not* optimal cases for modification endeavor; almost all failed to contract the disease. However, in the case of very young or sickly youngsters we may sensibly be less rigid in withholding the injection.

It is my feeling, tenable but not proved, that casual contacts may be expected to recur during epidemics. Injections given *prior* to adequate contact may prevent the disease entirely; this, to my mind, is *less* desirable than having the disease in an unmodified form. To avoid this, recently I have had the temerity to ask the parent whose child receives serum without known adequate contact, deliberately to expose him to a patient with measles. In the case of sensible individuals this works amazingly well.

Some physicians are unwilling ever to refuse injection because "if I do they'll just see another doctor". I cannot feel that such an attitude represents good medical practice. In the long run, adhering to one's principles will result in a more devoted, understanding clientele. If we all refuse to compromise, not only in this matter of immune globulin but in the giving of antibiotics and the like as well, our patients will be better off medically and economically.

CONCLUSIONS

1. In every case of home (sibling) exposure, measles modification, employing 0.02 cubic centimeter of immune serum globulin per pound of body weight should be attempted.

2. This amount may be increased in the very young or in sickly children.

3. Children with indefinite history of exposure, such as school and outdoor play, should *not* be given immune serum globulin unless special circumstances make it necessary.

460 Engle Street

SURGERY IN ACUTE PERFORATED ULCER

Whether to treat perforated peptic ulcers operatively or conservatively remains a controversial problem. Among surgeons there is also debate whether operative intervention should consist of simple closure or subtotal gastrectomy. On the basis of a review and analysis of 500 consecutive cases of acute perforated peptic ulcer admitted to Boston City Hospital between January 1938, and May 1950, Mikal and Morrison[1] have formulated the following scheme of management.

Simple operative closure is recommended for cases associated with early or late signs of generalized peritonitis, ulcers that exacerbate with a focal peritonitis, perforations over 24 hours that continue to leak. This procedure is also advised for patients who fail to respond to conservative management, for those with multiple perforations, and for those in whom the age or condition indicates a minimal procedure.

Primary subtotal gastrectomy should be done under the best surgical conditions in patients in good health, under 50 years of age, not in shock, and who have perforations of less than 12 hours' duration. It may be used in patients presenting questionable carcinoma with perforation, pyloric obstruction with perforation, perforations with hemorrhage, or with a history of previous perforation.

Non-operative management is advised for doubtful perforations, those less than 12 hours in duration that show signs of improvement, those accompanied by shock, and late ones which have sealed off or formed an abscess.

Six to eight weeks after perforation, subtotal resection is recommended for those in whom it has not been done as a primary procedure.

1. Mikal, S., and Morrison, W. R.: Acute Perforated Peptic Ulcer. New England Journal of Medicine, 247:119, July 24, 1952.

Medical-Surgical Plan of New Jersey

"New Jersey's Blue Shield Plan"

THE "SERVICE BENEFIT" PROGRAM OF MEDICAL-SURGICAL PLAN

The basic purpose for which Medical-Surgical Plan of New Jersey was developed in 1942—with the approval and guidance of The Medical Society of New Jersey—was to make available, especially to those in the low and moderate income groups, adequate medical service on a prepayment insurance basis for severe and unexpected medical and surgical contingencies. The intent was to help such people obtain service on a self-respecting private basis without resorting to free public services or burdening and disrupting the family budget in order to pay for such services.

This basic purpose remains unchanged to this day.

A considerable majority of the population is rendered medically indigent when confronted by a medical or surgical contingency beyond the most casual type. Yet most people want to protect themselves by voluntary action against the consequences of such medical contingencies by purchasing prepayment insurance.

The Blue Shield Plans, of which Medical-Surgical Plan is one, have responded to this demand. The soundness and success of the Blue Shield program is evidenced by the fact that in 10 years some 25 million people have subscribed to it.

Medical-Surgical Plan of New Jersey, as originally developed and as revised some four years ago, is designed potentially to provide inclusive "service benefits" to approximately 80 per cent of the population. This purpose has been supported repeatedly by formal action of the State Medical Society as well as by the endorsement of each of the county medical societies. Were it not for the Blue Shield program, there would long ago have been instituted by public demand some form of governmentally operated health insurance program. It is also conceded that it is better for the profession to support a program in which it supervises medical policy than to be forced to participate in a program over which it has no control.

The "service benefit" feature (distinctive to Blue Shield Plans and characteristic of most of them) provides an opportunity for the members of the profession to assure subscribers who are within the medically indigent category—insofar as important contingencies are concerned—that they, the physicians, are making a contribution to the solution of this problem by accepting the payment provided by the Plan as their full payment for services covered by the Subscription Contract and rendered to persons within that category.

Physicians sometimes do not understand that were it not for the "service benefit" feature, the Blue Shield program would never have been accepted so readily by so many of the working population, who most need such protection. Were it not for the "service benefit" feature, it is hard to see what justification the profession would have had for entering into the field of medical care insurance. If the profession were going to offer only cash indemnity, then such an effort might well have been left to the commercial insurance industry, over whose policies and programs, of course, the profession has no direct control or influence.

The medical profession in New Jersey has made a great investment and stands to reap enormous dividends through the public good will represented by the present membership of more than 900,000 New Jersey citizens in Medical-Surgical Plan. One out of every five persons in the state—and the number is growing daily—is now in a virtual partnership with the medical profession in this great enterprise, which constitutes a solid bulwark for the preservation of a free medical profession.

Approximately 80 per cent of all New Jersey physicians are presently supporting this effort as "Participating Physicians". Their participation, in reality, is as valuable to them as the Subscription Contract is valuable to the 900,000 subscriber participants. For just as Medical-Surgical Plan helps to stabilize the economy of the subscriber, so also it is helping to enhance and stabilize the economy of the profession itself.

These are a few of the reasons why the Trustees of Medical-Surgical Plan feel that the Plan merits—as much as it needs—the participation and cooperaton of every physician in New Jersey.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

INDICATIONS FOR RABIES VACCINE TREATMENT*

The committee considered the variation in indications for vaccine treatment at present used throughout the world. There was general agreement along the lines set forth in table I, which has been formulated with a view to reducing to a minimum the number of persons subjected to treatment unnecessarily.

Fairly often a situation arises in which a person previously exposed to infection and treated with vaccine is re-exposed to infection with rabies. The question as to whether treatment should be reinstituted and, if so, on what basis, must be answered. It is recommended that, if this situation arises within three months of the first course of vaccine, no further treatment is necessary unless the second exposure is of a severe type. If the interval is between three and six months, two reinforcing doses of vaccine, one week apart, are indicated, whereas if more than a six-months' interval has elapsed the treatment should be on the same basis as if it were an original exposure.

Occasionally, marked allergy to rabies vaccine manifested by angioneurotic edema, fever, adenopathy, shock, etc., is encountered. This may be during the course of immunization or, more often, following the administration of the first dose to a person who has previously received rabies vaccine. It is suggested that this difficulty may be circumvented by a change to vaccine made from the brain tissue of another species of animal (i.e., from rabbit-brain vaccine to sheep-brain vaccine).

INDICATIONS FOR VACCINE TREATMENT

Nature of exposure	Condition of biting animal: At time of exposure	Condition of biting animal: During observation period of 10 days	Decision as to vaccine treatment at time of possible exposure
I. No lesions; indirect contact only	healthy or rabid	healthy or rabid	none
II. Licks:			
(1) Unabraded skin	healthy or rabid	healthy or rabid	none
(2) abraded skin or mucosa	(a) healthy	healthy	none
	(b) healthy	clinically suspicious or proven rabid	start treatment at appearance of first suspicious signs
	(c) suspicious	healthy	start treatment immediately; stop treatment if animal remains normal for 3 days
	(d) animal rabid, escaped, killed, or unknown		start treatment immediately
III. Bites	(a) healthy	healthy	no treatment, except if bites are multiple, or face, head or neck bites; then treat as in III(c)
	(b) healthy	clinically suspicious or proven rabid	start treatment at appearance of first suspicious signs
	(c) suspicious	healthy	start treatment immediately; stop treatment if animal remains normal for 3 days
	(d) animal rabid, escaped, killed, or unknown; or any bites by jackel, wolf, fox, or other wild animal.		start treatment immediately

Note: Bites on the head, neck, and shoulders, deep multiple wounds, and those inflicted by wild animals involve a greater degree of risk, and patients should be treated accordingly.

*By Expert Committee on Rabies, April 1950. Reprinted from *WHO* Technical Report Series No. 28.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

John E. McWhorter, M.D., Reporter

The regular monthly meeting of the *Bergen County Medical Society* was held on October 14, 1952 at Bergen Pines Hospital, Paramus.

The following applicants were elected to membership: DRS. CARTER M. BALLINGER, RICHARD P. KEATING, PHILIP A. KILBOURNE, WALTER T. KUHNEN, GEORGE MILLER, JOHN E. ROSS, JR., RICHARD H. O'CONNOR, HERBERT E. FITCH, JR., GEORGE E. RANDALL and WILLIAM M. STUMPE.

The Secretary, Dr. John E. McWhorter, read a resolution on the death of one of the members, DR. GEORGE TIDWELL. The resolution was unanimously adopted.

The President, DR. G. BARLOW, made announcements concerning Better Breakfast Week, Diabetes Detection Week, the November meeting on the Medical-Dental School, the joint meeting in April with Passaic County, civil defense and the activities of a local hypnotist. Approval of the dues for 1953 was granted by the membership.

The rest of the meeting was devoted to a discussion of problems confronting the Society for the coming year and the Society's aims and program.

Plans were made for a testimonial dinner for members over 65 years of age, as an entertainment feature for the coming year. A discussion of the chiropractic problem followed along with a general discussion of legislative activities.

Public Health matters were considered, including plans for a proposed blood bank, hopes for the establishment of a Bergen County Chapter of the New Jersey Heart Association, and the showing of a play on mental health, sponsored by the Mental Health Association of Bergen County.

Membership interest was the next topic for discussion. Under consideration are plans to hold the regular meetings in other hospitals as well as Bergen Pines, sectional meetings of the specialties, and long range plans for the establishment of central headquarters for the Society.

Public relations in the doctor's practice, emergency medical calls, phone coverage, et cetera, were given consideration. Programs for the coming year, plans for the annual convention and work being done to lessen the large number of standing committees were all discussed.

A resolution was passed that the Society exert all its efforts to enroll each member in some active phase of medical civil defense and that the State Society be urged to appoint a Committee on Emergency Medical Service to coordinate its activities with the Council on National Emergency Medical Service of the A.M.A. and thereby guide the component county societies in this coordinated effort.

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

The first meeting of the 1952-53 season of the *Burlington County Medical Society* was held on September 11, 1952, at the Riverton Country Club. The meeting was called to order by our President, ARTHUR B. PEACOCK, M.D.

Dr. J. M. Nicholson, Chairman of the Program Committee, introduced the guest speaker of the evening—RYLAND CROSHAW, V.M.D., Instructor in the School of Veterinary Medicine, University of Pennsylvania. Dr. Croshaw's subject was "Diseases of Animals Transmissible to Man". He presented a very interesting paper which covered many diseases and pointed out that anthrax and brucellosis are perhaps the most important economically to the farmer of this area.

CAMDEN COUNTY

James P. Harbeson, III, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held at the Dispensary Building, October 7, 1952, with President COLLIER presiding.

DR. BERNARD I. SIMAN and DR. REUBEN BLOCK were introduced to the Society.

DR. W. EDWARD CHAMBERLAIN, Professor of Radiology, Temple University, gave a most interesting and practical talk on the "Harmful Effects of Irradiation and Their Avoidance". His discussion centered about the injudicious use of x-ray therapy in benign conditions and the cumulative effects of repeated exposures to such persons as dentists and fracture surgeons.

DRS. OTTO BROWN, FLORENCE C. SLATER, HUGH D. PALMER and EDWARD A. MITCHELL were elected to membership.

DR. ORNAFF, Chairman of "Better Breakfast Week Committee" advised the Society as to its meaning and asked their cooperation as an excellent public relations gesture.

There were 86 members present.

CUMBERLAND COUNTY

Frank J. T. Aitken, M.D., Reporter

The regular monthly meeting of the *Cumberland County Medical Society* was held October 14, 1952 at the White Sparrow Inn in Vineland, with DR. NORMAN W. HENRY presiding. Roll call showed 34 present and 4 medical guests.

Dr. Herbert Wilson was welcomed back after a prolonged absence due to illness. A report was tendered through the Secretary, Dr. Mary Bacon on the excellent program of the newly formed Woman's Auxiliary. Their suggestion that a buffet dance be given for the members of the Medical Society at the Cohansey Country Club in Bridgeton on December 6, was favorably received. President Henry reported on the five-part services to doctors through the American Cancer Society and invited a wider participation of members in this program.

An exceptional treat was given by the introduction of DR. TEMPLE FAY and his subsequent talk on

"Cerebral Palsy." The lecture was marked by its practicality, clarity and interest, as expected of this great teacher and surgeon. Dr. Fay summarized the international report from the recent meeting in Denmark.

At the conclusion of the scientific program an excellent dinner was enjoyed.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

With Don B. Weems, M.D. in the chair, the first fall meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, September 18, 1952.

The first part of the meeting was devoted to the scientific program, the speaker being Rachel Ash, M.D., Chief Cardiologist at the Children's Hospital, Philadelphia. With the aid of lantern slides, Dr. Ash excellently discussed "Treatment of Rheumatic Fever and Cardiac Anomalies in Children". William Beall, M.D., opened the discussion which was followed by a very informative question and answer period.

In reporting for the Program Committee, Louis K. Collins, M.D., stated that the speaker for the October banquet would be Senator H. Alexander Smith, who would discuss "America's Foreign Relations". It was decided to invite members of the press to the October session, as was done last year so successfully.

Chester I. Ulmer, M.D., reporting for the Public Relations Committee, mentioned the excellent publicity given this September meeting, and also discussed "Better Breakfast Week".

I. N. Patterson, M.D., of the Legislative Committee discussed the chiropractic bill intimating that it was not dead and urging us to be on our toes in opposition. Wendell Burkett, M.D., of the Legislative Committee also spoke about the bill and also mentioned the lowering of fines in violations of the Medical Practice Act.

Dr. Weems then appointed the following men to the county Judicial Commitee: J. Harris Underwood, M.D., Ralph L. Moore, M.D., and Baxter A. Livengood, M.D., with F. Griffith Wandall, M.D. and William W. Pedrick, M.D., to serve on the district Judicial Committee.

HUNTERDON COUNTY

John B. Fuhrmann, M.D., Reporter

The regular meeting of the *Hunterdon County Medical Society* was held on September 23, 1952 at 9:00 p.m. at Old Timbers Restaurant.

The meeting was opened by President Looloian with 60 per cent of the membership present. The following guests were introduced: James J. Sullivan, M.D., Bloomsbury, who has recently purchased the home and practice of E. W. Lane, M.D., of that town; Dr. Andrew D. Hunt, Jr., of Philadelphia, newly appointed head of the Pediatric Service of the Hunterdon Medical Center; and Dr. Morris Parmet of Allentown, Pa., newly appointed Director of Psychiatric Services at the Hunterdon Medical Center.

Dr. Ray Trussell reported on the progress being made by the Chronic Illness Survey being conducted in Hunterdon County and also on the project for a County Health Department which is now being attempted in our county.

Dr. Hunt was introduced as the speaker of the evening and gave us an enlightening talk on the use of antibiotics in the treatment of children.

After the meeting, a delicious buffet dinner was enjoyed by members and guests of the Society in conjunction with members of the Woman's Auxiliary who had met in an adjoining room.

MONMOUTH COUNTY

Sidney M. Hodas, M.D., Reporter

The first meeting of the *Monmouth County Medical Society* for the current season was held on September 24, 1952, at the Berkeley-Carteret Hotel, Asbury Park, with Dr. Anthony J. DeVita, the President, in the chair.

The feature of the evening was a presentation on "Management of Craniocerebral Trauma" by Dr. Edward B. Schlesinger, Attending Neurosurgeon at Neurological Institute, New York, and Associate Professor of Neurosurgery, College of Physicians and Surgeons.

Dr. Donald W. Bowne of Wanamassa was welcomed back by the Society after completing a period of service in the Air Corps.

Drs. Arthur W. Faust, Jr. of Long Branch, Albert J. Kolarsick of Shrewsbury and William C. Ballard of Rumson, were elevated to Active Membership.

Drs. Harold Gable of Elberon, Helen E. Greenleaf of Red Bank, George M. Massell of Matawan, Edward A. Scheuer of Farmingdale, and John D. Powers of Fair Haven, were elected Associate Members.

The resignation of Dr. F. Lawton Hindle from the Executive Committee was accepted.

MORRIS COUNTY

Albert Abraham, M.D., Reporter

The *Morris County Medical Society* held its regular meeting on October 16, 1952 at the Chilcott Laboratories, Morris Plains.

The program concerned reconstructive hand surgery and was presented by Dr. J. William Littler of New York City. Dr. Littler is a well-known researcher in this field and has contributed much original work. He showed many color slides of the types of problems to be encountered and described surgical procedure available for corrective surgery of the hand. A rich and varied experience, including his assignment at the Hand Center of the Army Hospital, Valley Forge during the last war, enabled him to demonstrate a number of novel technics.

PASSAIC COUNTY

David B. Levine, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society*, was held in the form of an

Installation Dinner, introducing DR. JOSEPH M. KEATING, the new President, to the Society. Dr. Keating spoke briefly on the theme which would govern his term of office—"Better Public Relations". The meeting was held in the Grand Ballroom of the Alexander Hamilton Hotel on September 17, 1952. The Emeritus Members, Drs. Joseph A. Maclay, Charles R. Mitchell, Charles J. Murn, Andrew B. Vanderbeek, Gordon G. Walton and Joseph H. Oram attended as guests of the Society; also the following who addressed the gathering briefly: DR. HARROLD A. MURRAY, President of The Medical Society of New Jersey; The HONORABLE LESTER F. TITUS, Mayor of Paterson; MR. RICHARD I. NEVIN, Executive Officer of the State Society. Other guests present included the Rev. William L. Griffin, who gave the invocation; The Honorable Morris Pashman, Mayor of Passaic; Mrs. Paul E. Rauschenbach, President of the Woman's Auxiliary to The Passaic County Medical Society; Mrs. Joseph M. Keating, Mrs. Sandor A. Levinson, Mrs. Floyd Fortuin, Mrs. Leopold E. Thron, Mrs. Joseph R. Jehl, Mrs. Theodore K. Graham, Mrs. David B. Levine, Mrs. John A. Ianacone and Mrs. S. H. Pink, who has so graciously been acting as hostess at the collation served after each regular monthly meeting.

A short business session was held, prior to the scientific meeting, at which the following were elected to Active Membership: DRS. MICHAEL R. RAMUNDO, Clifton; DOMINIC A. KUJDA, East Paterson; SANFURD G. BLUESTEIN and GEORGE K. TWEDDEL, JR., Paterson. Elected to Associate Membership were: DRS. JOSEPH F. MORIARTY and ARTHUR L. SILVERSTEIN, Passaic; DAVID ROTH, EDWARD M. GILLSON, and JOSEPH S. KRAKAUER, Paterson; ARCHIBALD FISHBERG, Fairlawn.

The chairman of the evening, Dr. Ianacone, introduced the speaker of the scientific session, ROBERT J. COFFEY, M.D., Director of the Department of Surgery, Georgetown University Hospital, Washington, D. C. Dr. Coffey's topic was "Diagnosis and Treatment of Acute Pancreatitis", and was illustrated with lantern slides.

SALEM COUNTY

Joseph H. Fishbein, M.D., Reporter

On October 17, 1952, under the chairmanship of its new president, DR. JOHN S. MADARA, the regular monthly meeting of the *Salem County Medical Society* was held at the DuPont-Pennsgrove Club. Dr. Harry Fullerton introduced the speaker of the day, DR. WILLIAM GAVENTA who had recently returned from a three year tenure as a medical missionary at the American Baptist Mission in Nigeria, Africa.

Dr. Gaventa's talk was by far the most interesting one heard by the society for some time. He described the leading diseases encountered—malaria, parasitic infections, and malnutrition—citing the large number of juvenile portal cirrhosis seen in Africa. Illustrative slides of his work were shown.

This interesting talk was followed by a business meeting at which dues for the coming year were set at $35.00. DR. JOSEPH H. FISHBEIN was elected Alternate Delegate to The Medical Society of New Jersey Annual Meeting, to fill an opening caused by the sudden death of Dr. Maurice Chesler.

Announcement was made by Dr. Ford C. Spangler of the creation of a Baby Keep Well Station in Salem with participation of all the doctors in that area.

A Diabetic Detection Committee was appointed with Dr. Isadore Lipkin as chairman. Serving on this committee will be Dr. Charles Norton and Dr. August Jonas.

The Nutrition Committee report was given by Dr. Harry Fullerton who disclosed his plans for participation in the Better Breakfast Week by sponsoring a breakfast at the Country Club with the aid of the local merchants.

NEW JERSEY SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Albert F. Moriconi, M.D., Secretary

The Society was organized on June 8, 1952, and the following officers were elected: President—HENRY B. ORTON, Newark; First Vice-President—ARTHUR SACKS-WILNER, Trenton; Second Vice-President—ORAM R. KLINE, Camden; Secretary—ALBERT F. MORICONI, Trenton; Treasurer—THOMAS V. MURTO, Trenton; Historian—CHARLES W. BARKHORN, Newark; Council—EDGAR P. CARDWELL, Newark; E. A. Y. SCHELLENGER, Camden; BAXTER H. TIMBERLAKE, Atlantic City and JOHN SHEEDY, Plainfield.

The purposes of the Society are to advance and promote the science of otolaryngology and ophthalmology; cultivate social contacts among its members; and to honor those who by their contributions in this field have aided in its advancement.

NEW JERSEY ORTHOPAEDIC SOCIETY

William Kruger, M.D., Secretary

The *New Jersey Orthopaedic Society* held its annual fall meeting at the Kessler Institute in West Orange, on October 11, 1952. The following officers were elected: President—PAUL J. FINEGAN, Trenton; President-elect—HENRY H. KESSLER, Newark; Secretary—WILLIAM KRUGER, Newark and Treasurer—HAROLD T. HANSEN, South Orange.

DR. ROBERT BRENDZE of Jersey City presented his paper on "Judet Arthroplasty" which won the Society's 1952 award. The rest of the program was devoted to the problems of rehabilitation of the paraplegic and of those with congenital defects. The following papers were presented:

DR. LUDWIG GUTTMAN of England—"Rehabilitation of the Paraplegic"; DR. DOUGLAS P. MURPHY of the University of Pennsylvania—"Statistical Aspects of Congenital Defects"; DR. SALOME GLUECKSHON-WAELSCH of Columbia University—"Genetic Aspects of Congenital Deformities"; and DR. ROBERT L. KORNS of the State of New York Department of Health—"Epidemiological Aspects of Congenital Defects".

WOMAN'S AUXILIARY

Essex County

Mrs. Louis L. Covino, Chairman, Press & Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held a combined Dinner Meeting with the Essex County Medical Society to honor HARROLD A. MURRAY, M.D., President of the State Medical Society, on October 8, 1952, at the Hotel Suburban, East Orange. Mrs. Jerome Kaufman, President of the Auxiliary, extended greetings. Some 30 persons were present, making it the largest gathering of our county group, which is the sixth largest in the nation.

Miss Ann Carstensen, our first Nurse Scholarship Award winner, graduated in September from Orange Memorial Hospital School of Nursing. She is an outstanding example of the benefits derived from our foremost project, our Nurse Scholarship Fund. We have several other girls on scholarship in various nurse training schools throughout the county.

The Blood Bank at City Hospital is still active under the chairmanship of Mrs. Irving Borsher. The amount of blood replacements in the bank have increased somewhat but the demand for blood is still far ahead of the desperately needed replacements.

Mrs. Jerome Kaufman, President of the Auxiliary, was hostess at a luncheon for the members of her Executive Board, at the Downtown Club, Newark, on September 23.

Hudson County

Mrs. Moses Dolganos, Chairman, Press and Publicity

The *Woman's Auxiliary to Hudson County Medical Society* held its first regular monthly meeting of the fall season on October 6, 1952 at Murdoch Hall, Jersey City Medical Center. Mrs. Albert Lepis, President, presided.

A social hour preceded the meeting during which the hostesses, Mrs. James Tsucolos and Mrs. Marshall Bergen, served homemade refreshments which were quite an attraction.

Miss Ann Murphy, Director of Nurses, Jersey City Medical Center, was the guest speaker. Miss Murphy's subject was "Nurse Recruitment". She explained the increased demand for nurses in terms of the constantly expanding services and the tremendous increase in the number of patients cared for in hospitals today.

Miss Murphy thanked the members for their fine interest and cooperation, and introduced to the members two young ladies in uniform who were last year's beneficiaries of the scholarship fund. The young student who will receive the Auxiliary scholarship to the Medical Center for the current year was then introduced.

The Committee for Better Breakfast Week, announced plans to support the efforts of the Hudson County Medical Society in this project.

Mrs. Joseph Giannasio, Membership Chairman, introduced four new members—Mrs. Theodore Saxe, Mrs. George Costa, Mrs. Francis Mara and Mrs. Michael Berman.

BOOK REVIEWS

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of Northern New Jersey

The Low Fat Diet Cook Book. By Dorothy Myers Hildreth and Eugene A. Hildreth, M.D. Pp. 148. New York, Medical Research Press, 1952. ($2.95)

In this cookbook, all recipes are worked out to be as palatable as possible for patients who are on a low fat or low cholesterol diet. The book is intended for use by the family as if it were a prescription blank from the doctor.

Since the medical profession is so concerned these days with the work done on atherosclerosis, further information on the control of this disease must be placed in the hands of the one who prepares the patient's meals. This book is a "must" for every hospital diet kitchen and for every home where there is an arteriosclerotic patient.

S. WILLIAM KALB, M.D.

Functional Endocrinology. By N. B. Talbot, M.D., E. H. Sobel, M.D., J. W. McArthur, M.D., and J. D. Crawford, M.D. Pp. 638. Cambridge, Mass., Harvard University Press, 1952. ($10.00)

Endocrinology has made tremendous strides in the past few decades, and is still the subject of intensive investigation. From time to time it is necessary to evaluate critically the progress that has been made, to summarize the extent of current knowledge, and to define the practical clinical significance of laboratory research. In this volume the authors have done an admirable job in presenting current concepts of human endocrinology in all its phases. There are nine chapters, dealing successively with the thyroid, parathyroid, adrenal cortex and medulla, ovaries, testes, anterior and posterior pituitary

glands, and pancreatic islets. Each chapter starts with basic physiologic principles, outlines methods of determining normal function, and then reviews pathologic deviations from the physiologic state. Clinical details and methods of management of endocrine disorders are discussed. No detail is overlooked, so that non-endocrinologic diseases, renal rickets for example, are described and compared with the true endocrinopathies.

The book is excellently written, and the text is clarified with numerous charts, diagrams, and photographs. Although dealing primarily with endocrine function and dysfunction in children and young adults, the material presented is so basic that insight is necessarily gained into adult endocrinology.

This volume should appeal to every student of medicine, and to every physician with an interest in endocrinology. Although best appreciated when read cover to cover, it is also well enough organized and indexed so that it will serve as a useful reference book for quick research in this field.

ULYSSES FRANK, M.D.

Surgery of the Chest. By Julian Johnson, M.D., and Charles K. Kirby, M.D. Illustrations by Edna Hill. Chicago, Year Book Publishers, Inc., 1952. ($9)

Here is an excellent and timely guide for residents and surgeons interested in and practicing thoracic surgery. The book deals with every operation currently performed on or within the thoracic cage. Approximately a third of the text is devoted to related basic subjects such as physiology, the more common and useful pulmonary function tests, pre- and post-operative care, surgical anatomy, and the incisions needed for thoracic operations. Each operation is thoroughly described and well illustrated. Drawings demonstrate the operative procedure step by step. The authors, while stating their own preferences, demonstrate the operative approach and technic in different positions, particularly for pulmonary resection.

The rapid progress now being made in thoracic surgery, particularly in surgery of the esophagus, the heart and great vessels, has created a large gap in comparatively recent textbooks on thoracic surgery. This work fills this void by two comprehensive and adequate chapters on these subjects. Frequent referrals to this volume will often serve as a torch to illuminate the varying anatomic structures that sometimes are ill-defined and distorted as they have been camouflaged by pathologic processes.

HENRY A. BRODKIN, M.D.

Stereo-encephalotomy. E. A. Spiegel, M.D., and H. T. Wycis, M.D., New York, 1952. Grune and Stratton. Pp. 176. Including an atlas of 79 figures and a transparent coordinate square sheet.

Neurosurgery will become an exact science as soon as it is possible to produce sharply defined, exactly localized lesions with an operating electrode. When this becomes possible, our present methods of wide surgical exposure of the brain and damage to overlying and adjacent tissues will seem painfully crude. The stereo-encephalotome is the most promising device yet offered in that direction. In essence, it is a method of holding the skull firmly, using well recognized base points, and introducing an electrode so that its effect is produced at the exact spot desired, as measured from one of the base points. This unique book contains a description of, and photographs of the apparatus, as well as detailed descriptions of the pre-operative, operative and postoperative technic. The bulk of the volume consists of a stereotaxic atlas of the human brain in which all the major intercerebral landmarks are located with reference to several fixed base points. Each photograph is framed in a box of coordinate guide lines, and included in the book is a transparent sheet, cross hatched with coordinate rulings so that exact localization becomes possible. This is pioneer work, which even now should be an indispensable source book for the neurosurgeon and an essential reference volume for the neurologist. It seems certain that this will eventually become the classic volume in its field and a milestone in neurosurgical history.

SAMUEL L. POLLOCK, M.D.

Physical Diagnosis. By H. Walker, M.D. Pp. 461. St. Louis, C. V. Mosby Co., 1952. ($8.00)

A new book about a basic subject ought to present the material in a novel fashion; develop new concepts; or appeal to a special group. Otherwise, there is no reason for adding to an already voluminous literature. Dr. Walker's book adds little that is new or different when compared to the classics in its field, already familiar to generations of physicians.

The first section outlines history taking, and methods of examining the patient. Section Two and Three deal with diseases of the respiratory and circulatory systems. This arrangement here is cumbersome. The student first becomes acquainted with cardiac murmurs in the chapter on auscultation of the circulatory system; and then must turn to the last section to determine the murmurs associated with valvular diseases. It would seem more logical to include the specific murmurs of each cardiac disorder with the chapter on cardiac auscultation, so that there would be unity to the subject. Similar comments apply to the chapters on examination and diseases of the respiratory system.

The last two sections serve as short textbooks of medicine, outlining the specific diseases of the respiratory and cardiac systems, dealing with the pathology and physical signs for each. This material is better left to a complete textbook of medicine, where the student will find comprehensive data about each disease. I doubt if it belongs in a book on physical diagnosis.

Eponymic signs and syndromes are not well emphasized (which would be of value to a physician preparing for specialty examinations). Diagrams and illustrations are not outstanding. Statements about controversial topics are often presented dogmatically.

H. I. GOLDSTEIN, M.D.

Principles and Methods of Physical Diagnosis. By Simon S. Leopold, M.D. With a chapter on "Sounds from the Thorax: Acoustic Principles", by S. Reid Warren, Jr., Sc.D. 390 pages with 19 color plates. Philadelphia, Saunders Co., 1952. ($7.50)

Dr. Leopold describes concisely and in simple language the correlation of physical signs with the physiologic and pathologic changes in disease with which they are commonly associated. The book holds one's interest. It is so written that it is a welcome addition to the library of the hard pressed practitioner. The illustrations are excellent and the references are few but adequate. The chapter on history taking is particularly good. It appears to the reviewer to be an excellent work and one for which there is need both by the general practitioner and by the student beginning the study of medicine.

Joseph I. Echikson, M.D.

Surgical Forum: Proceedings of the 1951 Clinical Congress of the American College of Surgeons. Pp. 667 with 290 figures. Phila., W. B. Saunders Company, 1952. ($10)

This is undoubtedly one of the most comprehensive discussions of practically every phase of surgery that I have ever seen. A detailed review of this work is out of the question primarily because no one person could find it in his scope of knowledge to understand all its aspects. I shall, therefore, confine my observations to the portion of the book that deals with subjects of interest to the general surgeon. I found of particular value the experimental work on gastro-intestinal suturing, and this whole section of the book generally is of great interest. The plates and drawings are outstanding for their clarity and detail. The section on the liver and portal system is also excellently done. If the parts of the volume, with which I am not familiar, have the same merits as the section on general surgery and chemical balance, this is a work that should be in every surgeon's library.

E. V. Parsonnet, M.D.

Working Programs in Mental Hospitals. Proceedings of the 3d Annual Mental H spital Institute. American Psychiatric Association, Washington, D. C. 1952. Pp. 203. ($2.50)

In October 1951, the American Psychiatric Association held an "Institute" in Louisville at which many practical problems of mental hospital administration were thrashed out. The meeting included lectures, moving picture films, psychodrama demonstrations, and, above-all, the give-and-take of free discussion. A broad kaleidoscope of topics was covered including ward standards, relationships with universities, personnel problems, financing, food preparation, research, geriatric patients, treatment technics, and the handling of patients' relatives.

The idiomatic feature of this volume is the stenographic transcription of the actual discussion —the incisive questions asked, the practical problems presented, the down-to-earth method of meeting those problems. If the editors had added an index, the book would have been a gold-mine for the hospital ward officer and administrator, since by opening it to his particular problem he would, at once, have had the opportunity of sharing the problem with many others in the field. A somewhat similar desideratum may be achieved if the reader will examine the table of contents and turn to the section focussed on his immediate area of interest.

William Schram, M.D.

Sex After Forty. By S. A. Lewin, M.D., and John Gilmore, Ph.D. Introduction by the Rev. Dr. Russell L. Dicks. 200 pages. Illustrations. Medical Research Press. New York, 1952. ($3.50)

An exposition that will ease the physician's task, *Sex After Forty* is an adjunct to, not a substitute for, seeing a doctor. The authors have stated in simple terms the problems set seething by the climacteric and have charted a clear course for the patient. If their advice on some of the difficulties that are not purely medical is at times banal, (more like that found in the "allure" or "glamour" magazines than in a scholarly work) it is none the less responsive to the questions and doubts troubling so many of the persons to whom the book is addressed.

Excellently illustrated, *Sex After Forty* includes valuable addenda: a list, by states, of counseling agencies, a glossary and case histories. The last item is perhaps the most helpful therapeutic section of the book. One wonders whether it would not have served the reader and the authors better to have used the case histories as a preface than to have placed them near the end.

Victor Huberman, M.D.

Physical Medicine in General Practice. Edited by William Bierman, M.D., and Sidney Licht, M.D. 3d ed. Pp. 798. N. Y., Paul B. Hoeber, Inc., 1952. ($12.50)

This new edition, revised with the collaboration of 22 authorities, covers the entire field of physical medicine. It is a valuable working text for the general practitioner, specialist and technician. The first 15 chapters are devoted to procedures with physiologic changes and activities. Part II, contains 14 chapters conservatively devoted to those conditions, both disease and injury, in which the methods and equipment utilized in the practice of physical medicine may be applied.

The chapter on the "Conduct of Treatments" should be studied by all who intend to use physical measures. It will help him avoid accidents and injuries to patients during treatment. The specific dangers in the use of exercise, ultraviolet radiation, thermal measures, hydrotherapy, phototherapy and infra-red radiation, long and short wave diathermy, and electric shock are pointed out.

New chapters dealing with functional muscle testing, microwave diathermy, manipulation, neuromuscular re-education, ultrasound, and the care of amputees are welcome, modern inclusions. As a whole, the volume reflects the best concept of 20th Century physical medicine.

Jerome H. Samuel, M.D.

TUBERCULOSIS

ABSTRACTS

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Vol. XXV **November, 1952** **No. 11**

THE TUBERCULOUS DIABETIC PATIENT

By Michael A. Ferrara, M.D., The New England Journal of Medicine, January 10, 1952.

A total of 3,178 patients with pulmonary tuberculosis were admitted to the Uncas-on-Thames Tuberculosis Hospital from July 1, 1937 to July 1, 1950. Of these, 68 or 2.1 per cent had associated diabetes mellitus. This study is concerned with the course of tuberculosis in these diabetics and with their present status.

Many writers believe that some peculiar relation exists between diabetes mellitus and tuberculosis and that the diabetic is more prone to develop tuberculosis than is the nondiabetic. Some authorities have stated that the prevalence of tuberculosis is more than three times as high among diabetics than among the general population. It has been shown that the frequency of pulmonary tuberculosis in diabetics at autopsy appears to be at least two to four times as great as it is in nondiabetics. The mortality from tuberculosis among diabetics has shown no fall comparable with the fall in rate among the general population. The causes of the increased susceptibility of diabetics to tuberculosis and of these patients' poor resistance to their disease after it has developed (if this is true) are not known. Numerous explanations of this have been offered, but to date the answer is still conjectural. Hyperglycemia, acidosis, increased glycerol production, altered function of the leukocytes and tissues in general and lowered pulmonary concentration of phospholipids and lipids have all been advanced as possible causes.

Early recognition and prompt treatment of tuberculosis in the diabetic is, of course, of great importance if this condition is to be arrested in a higher proportion of diabetics than has heretofore been true. It has been stated that the average life expectancy of a tuberculous patient with diabetes is barely half what it would be in one with tuberculosis uncomplicated by diabetes.

Tuberculosis discovered in the minimal stage in a diabetic is rare. This is shown in the literature and is corroborated by this study. Of 68 patients studied only one had minimal tuberculosis. Of the remaining 67 cases, 16 or 24.6 per cent were moderately advanced and 51 or 75 per cent were far advanced. Of the 68 patients, 53 have been discharged and 15 are still hospitalized. Of the 53 discharged, 35 are known to be dead, two are alive with active tuberculosis, the disease has been arrested in 11 for a period ranging from six months to nine years and five are untraceable. Of the 15 cases still hospitalized, seven have active tuberculosis, unimproved, and the disease of eight is active, improved. It would appear, then, that the prognosis for the patient with tuberculosis and diabetes is poor—and worse than for the patient with tuberculosis alone.

The diabetes did not militate against the use of any form of therapy for any of the patients in this study, and all forms of tuberculosis therapy were used as indicated. Usually, the diabetics with tuberculosis did not respond to treatment as well as did the nondiabetics. In the great majority of cases, the end result was either death or a long course of hospitalization with slowly progressing tuberculosis.

The X-ray appearance of the tuberculosis in this series of diabetics was not significantly different from that in nondiabetics.

The diabetes was mild in 11 per cent, moderate in 28 per cent and severe in 61 per cent of

the cases. It was diagnosed prior to the discovery of tuberculosis in 47 or 69 per cent and after tuberculosis developed in five or seven per cent of the cases. The two diseases were diagnosed together in 16 or 24 per cent of the total. Table 1 shows the duration of diabetes prior to the development of tuberculosis.

TABLE 1

DURATION OF DIABETES PRIOR TO THE DEVELOPMENT OF TUBERCULOSIS

Duration of disease	Number of patients
0- 2 years	8
3- 5 "	15
6-10 "	15
11-15 "	6
16-20 "	2
21-25 "	1

Frequent routine X-ray examination of the lungs of all diabetics would uncover tuberculous lesions in earlier rather than advanced stages and might well improve the prognosis for their tuberculosis.

The blood sugar was kept below 150 mg. per 100 cc. wherever possible; this was achieved in the majority of cases. No significant relation was noted between the degree of control of the diabetes and the course of the patient's tuberculosis. The diabetic status of the 11 arrested cases was no different from that of the majority of the other 57 patients.

More than two thirds of the patients were over forty-four years of age. The older diabetic should not receive X-ray examination less frequently than others merely because of age. Table 2 shows how long those who died lived after their tuberculosis was diagnosed. Only three patients lived longer than six years; 50 per cent died within two years.

TABLE 2

DURATION OF LIFE AFTER TUBERCULOSIS WAS DIAGNOSED

Duration of life	Number of patients
0-1 year	9
1-2 years	10
2-3 "	5
3-4 "	5
4-5 "	—
5-6 "	3
6-7 "	—
7-8 "	2
8-9 "	1

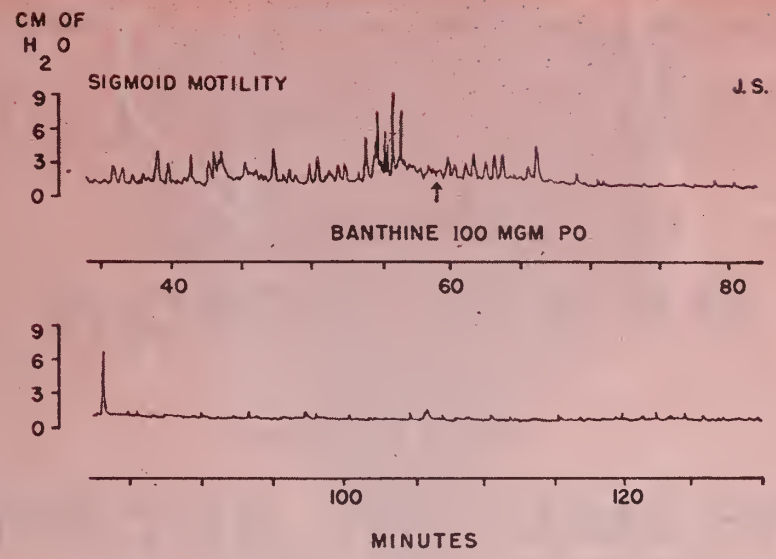
CONCLUSIONS

Of 3,178 patients admitted to the Uncas-on-Thames Tuberculosis Hospital with pulmonary tuberculosis from July 1, 1937 to July 1, 1950, 68 or 2.1 per cent had associated diabetes mellitus. Of the 68 patients, 53 were discharged and 15 are still hospitalized. Of the 53 discharged, 35 are known to be dead, the disease has been arrested in 11 for periods ranging from six months to nine years, two are living with active tuberculosis and five are untraceable. Of the 15 patients still hospitalized, the disease of seven is active, unimproved, and the disease of the remaining eight is active, improved.

The prognosis for the tuberculous patients who have diabetes is graver than for the tuberculous patient who does not have diabetes.

All diabetics should have a chest X-ray examination at least every six months—or more often, if signs or symptoms warrant more frequent X-ray examination of the chest.

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2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, Gastroenterology *17*:551 (April) 1951.

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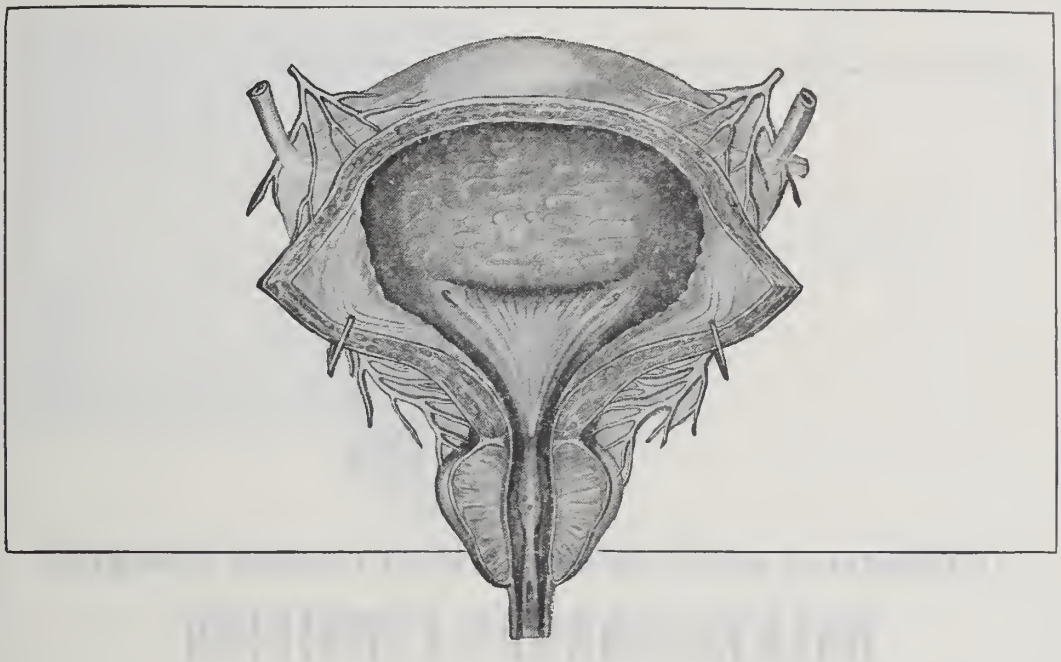
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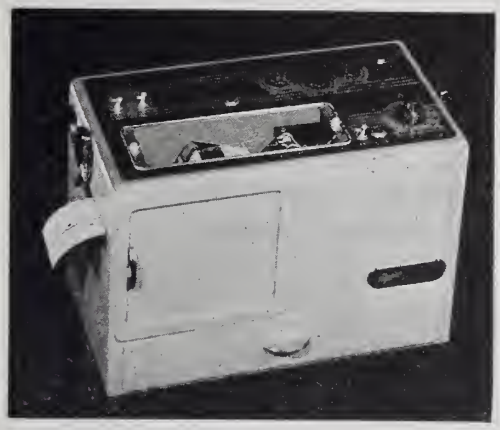
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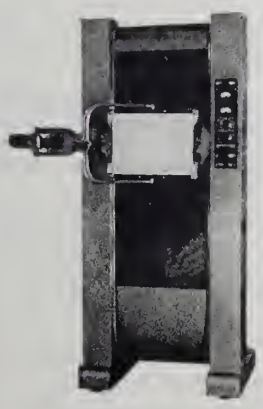
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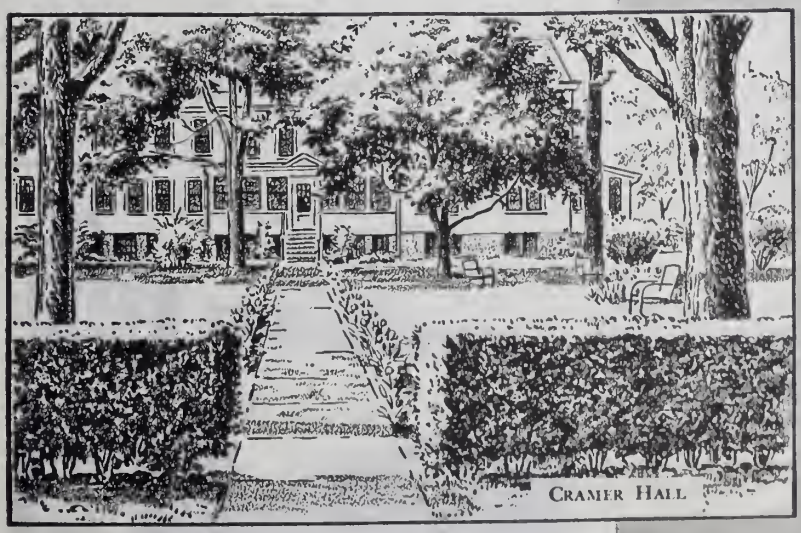
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Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

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31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

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*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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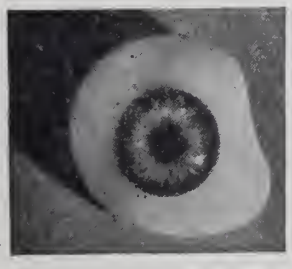
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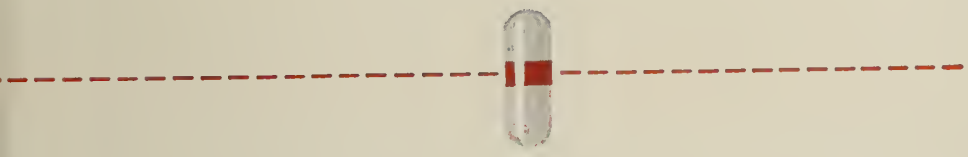
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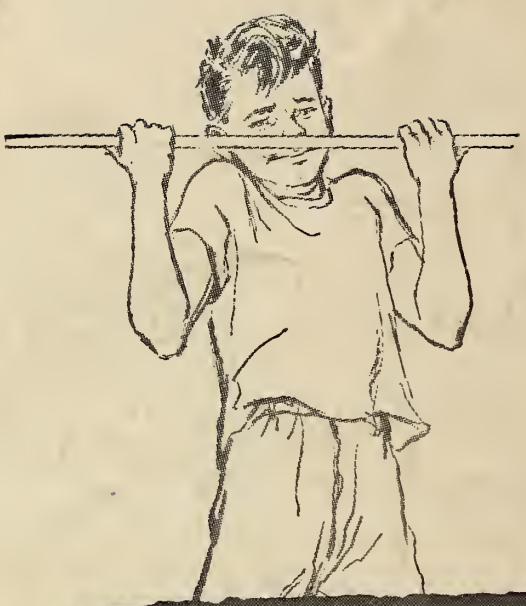
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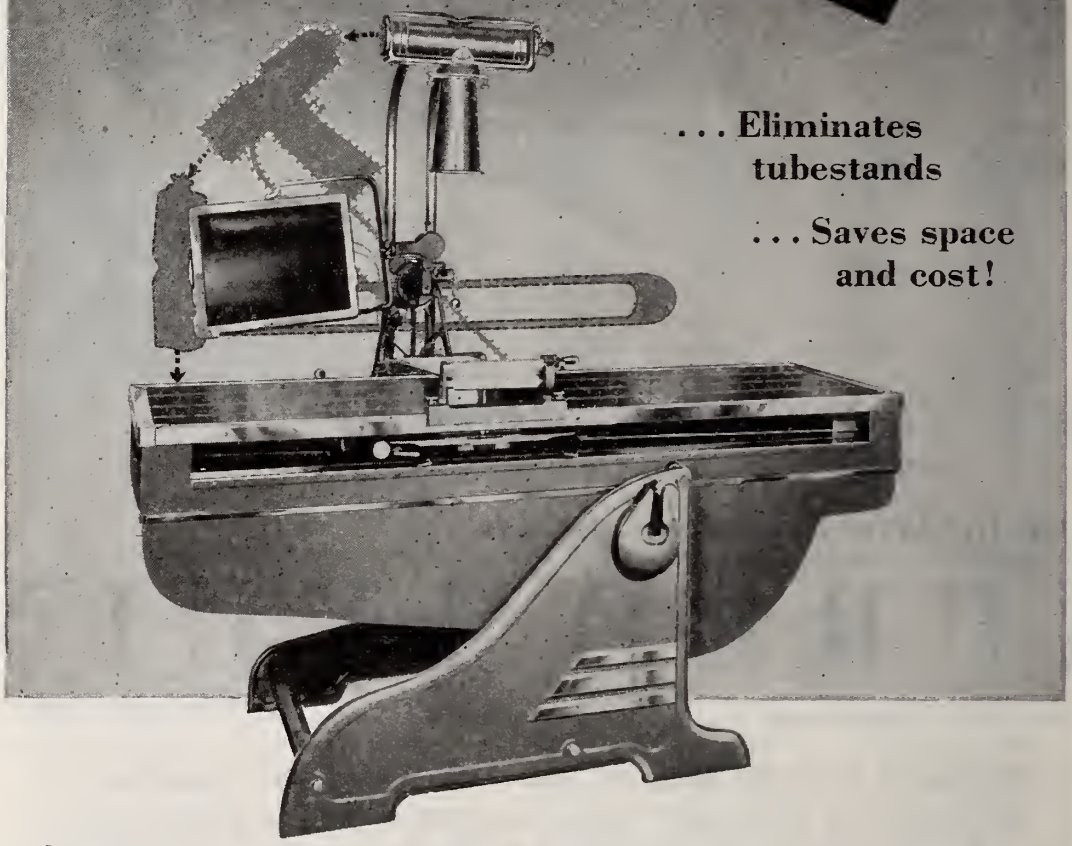
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Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
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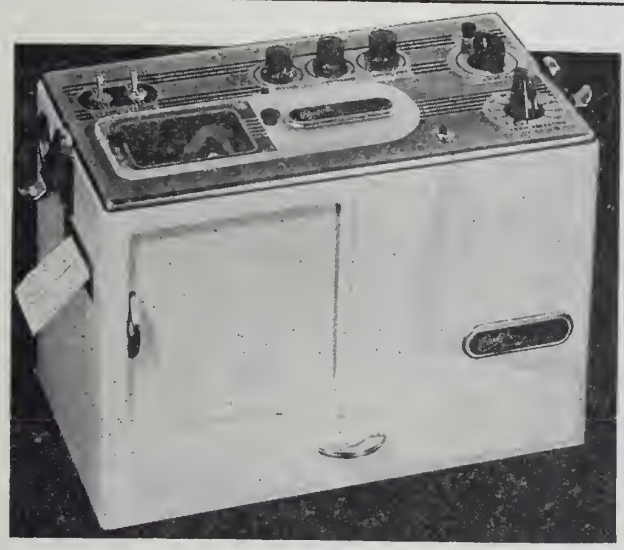
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FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
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1. Van Alyea, O. E., and Donnelly, Allen: Arch. Otolaryng., 49:234, Feb., 1949.

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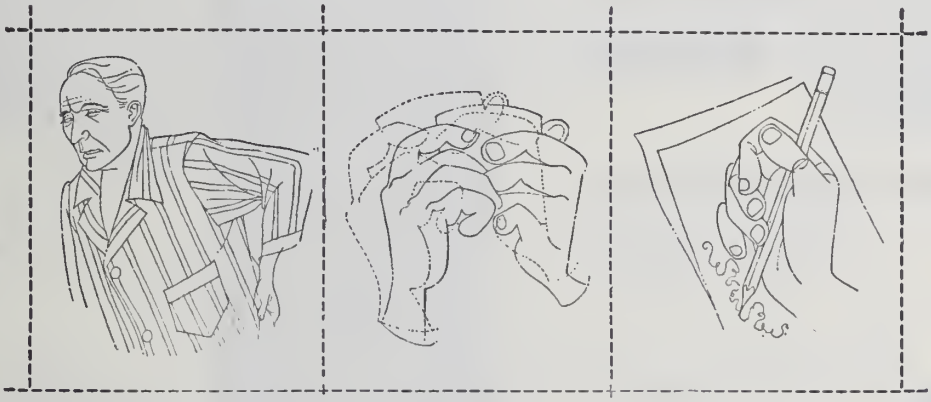


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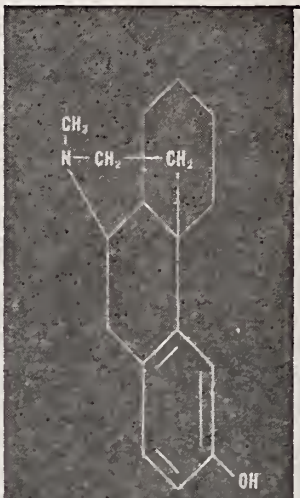
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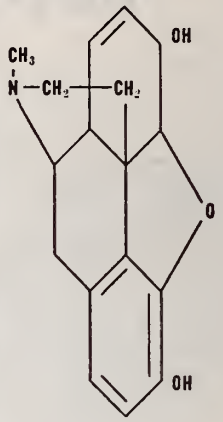
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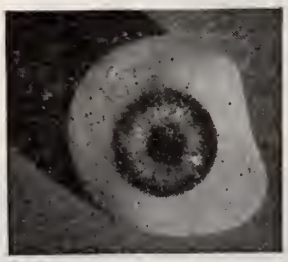
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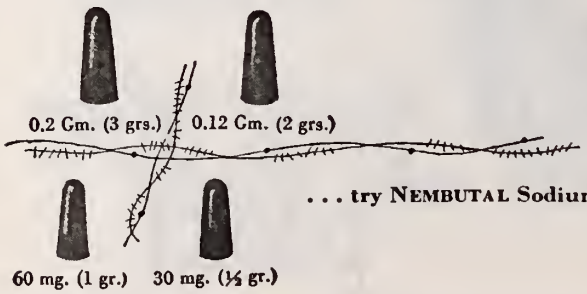
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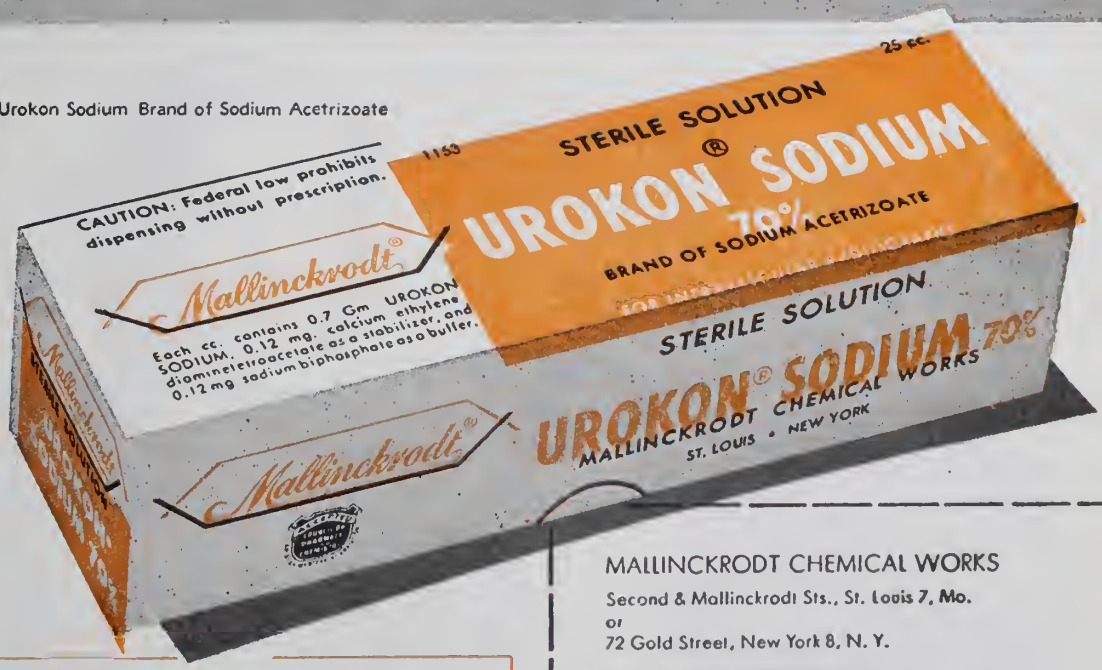
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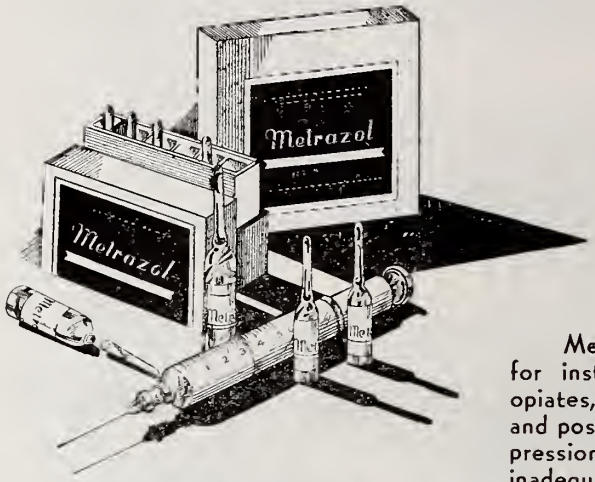
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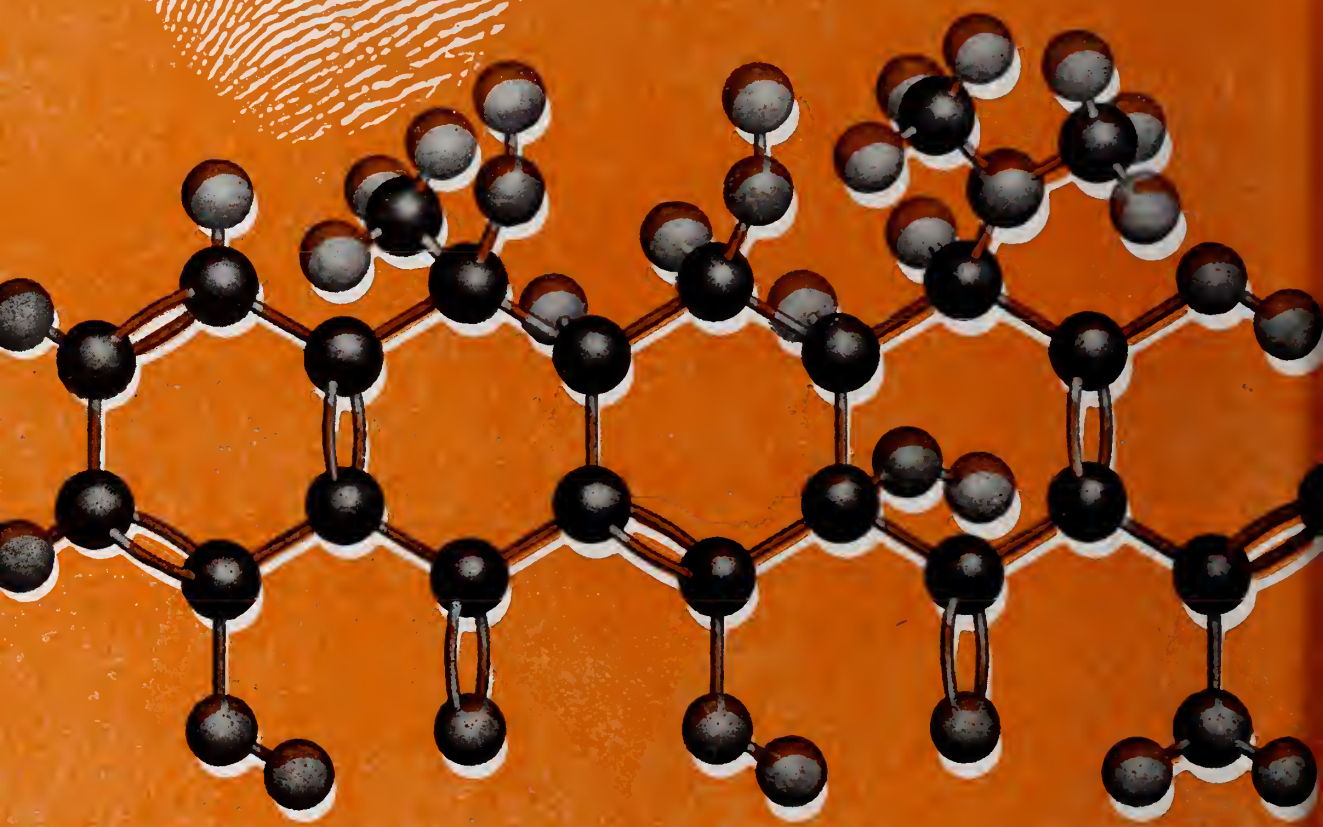
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PRESIDENT'S MESSAGE

SEASON'S GREETINGS

Each year there comes a time when it is our opportunity to express to friends and colleagues best wishes for continued good health, prosperity, and happiness. The time is approaching when again this privilege will be ours.

This is a worth-while custom and over the years greater emphasis has been placed upon its true meaning. It is a time when we should take an inventory, so to speak, of ourselves. We in the medical profession cannot take stock of merchandise on hand, but we can evaluate our personal and professional assets. This we should do in a most objective manner.

In what way have we as doctors contributed to the general welfare and happiness of our family and neighbors? Have we lived up to the high concepts of our profession—the ideals and pledges that we made when we received permission to engage in the healing art? Have we made ourselves available to our people when they needed our help? Have we rendered medical care within the patient's ability to pay for our services? Have we endeavored to add to the betterment of our fellowman by planning for his well-being in the community in which we live?

These are some of the questions which we should ask ourselves this month as we approach the New Year. Perhaps we will make some new resolutions which we shall try to carry out in Nineteen-hundred and fifty-three.

Your Officers and Members of the Board of Trustees join with me in extending to each member of the Medical Society and his family a very Merry Christmas and a most Prosperous and Happy New Year. It is my earnest hope that the good Lord will shower upon each one of you His choicest blessings.

HARROLD A. MURRAY, M.D.

THE PRESIDENT'S COMMISSION ON HEALTH

The nation's physicians play a multifaceted role in their communities throughout the country. First, they are practitioners, charged with the care of the ill. They are also called on in matters of public health, hospital management and administration, and a myriad of other duties. Finally, each physician by training and occupation is a scientist, and as such is committed to the search for truth. This search may lead to collection and dissemination of scientific material or to an evaluation of socially significant data. As scientists, physicians are expected to be able to analyze data, weigh various factors, and arrive at sound conclusions; in this process extraneous influences and prejudices are to be excluded.

With these thoughts in mind, Dr. Paul B. Magnuson, chairman, outlined the aims and plans of the President's Commission on Health Needs of the Nation in an address before the Medical and Chirurgical Faculty of the State of Maryland in Baltimore on April 30. He stated that he had been promised an absolutely free hand in choosing the members of the commission, and that he chose them with no regard to each man's political affiliation or ideologic leanings. No one from a government agency has been placed in any policy making position.

The commission was directed to investigate, in as an impartial and scientific manner as possible the nation's total health requirements, including the current and prospective supply of physicians, dentists, nurses, and other health workers; the ability of educational institutions to fulfill these needs; the ability of local public health units to deal with civil defense requirements; the needs and effectiveness of medical facilities, hospitals and clinics; research activities in the field of health; civilian health requirements in relation to military, veterans' and civil defense health needs; adequacy of private and public programs for financing medical care; the extent and role of federal, state and local government services in health fields; and allied topics.

This tremendous undertaking is being met by the "hearing" method, in which representatives of various interested organizations are invited to sit down at a table and thrash out these problems, and present data for review and digestion by other panel members. Dr. Magnuson doubts whether this huge job can be done in a single year, but at least he has started to tackle it.

At the American Medical Association Convention this year the House of Delegates voted to await the Commission's first report before passing judgment. This seems a prudent move. Investigators of such caliber as these deserve a hearing before they are condemned. If subsequent developments prove that this commission is merely a "big-name" sounding board for propagandizing in behalf of socialized medicine, then the physicians of this country will be justified in exposing it for what it is. If the commission frees itself from this taint, produces a clear evaluation of the nation's health needs in all its aspects, and presents recommendations of an intelligent and acceptable nature, it will deserve the accolade of the entire population. It seems only fair at this time to withhold comment until the evidence is at hand. Such a course by the medical profession will win far more respect and approval than premature criticism of an incompleted task.

CHRISTMAS SEALS

Most of us today cannot remember when there were no Christmas seals, or when tuberculosis was rampant, with hundreds and thousands of adults and children dying yearly of "consumption". The change in status has been brought about to a great extent by the unceasing efforts of the National Tuberculosis Association, born right here in New Jersey, which has sponsored the sale of Christmas seals for the past 46 years.

Yet in spite of the progress that has been made, tuberculosis is still number seven killer in the United States, and remains the top killer among infectious diseases. Moreover, the tragedy of tuberculosis strikes the young adult; the youth just starting to make his way in the world, the young woman at the threshold of a career or family. In removing these members from the community tuberculosis wreaks the greatest havoc.

Tuberculosis, however, is a contagious disease, controllable by modern public health measures, and almost eradicable by present methods of treatment, especially if detected in its early stages. To achieve this goal we need community x-ray surveys, nursing and social services, tuberculosis clinics and sanatoria, further research, and a host of other activities.

In the past these endeavors have been carried out by the National Tuberculosis Association and its state affiliates, which are financed largely by funds collected through the sale of Christmas seals. We must insure the future against tuberculosis by supporting this worthwhile organization. So make it a point to order an extra sheet of seals this year. When you stamp on a seal, you help stamp out TB.

SMOKING AND ASTHMA

Too often in the practice of medicine one is tempted to prescribe a number of drugs which are of varying efficacy, and overlook the significance of the simplest therapeutic measures. A case in point is the interdiction of smoking in patients with asthma. Peters *et al.** have recently reported on the harmful effects of smoking in patients suffering from asthma. They point out that most asthmatics have some degree of bronchitis, as evidenced by inflamed, red, swollen mucous membranes, covered with thick tenacious mucus, and accompanied by bronchospasm. These inflamed mucosal surfaces are sensitive to irritants such as dust, smoke, fumes, cold air and strong odors. Smoking is a very common source of bronchial irritation and invariably increases coughing and wheezing. Asthmatics should be taught this fact, and advised against smoking. Regardless of cigarette ads, all types of smoke are irritating to mucous membranes; filters and other devices are of little value in allaying this irritative effect.

To be effective, smoking by an asthmatic patient must not be reduced, it must be completely stopped. Even so-called asthma cigarettes, or burning powders, which contain stramonium or nitrates, are contra-indicated, as the smoke itself is the aggravating factor for these patients.

The prohibition of smoking, therefore, should be added to the anti-asthma regimen, along with management of allergy problems and the use of bronchodilating drugs.

* Peters, G. A., *et al.*: Smoking and Asthma. Proceedings of the Staff Meetings of the Mayo Clinic, 27:329 (August 13, 1952).

ORIGINAL ARTICLES

THE OPERATIVE TREATMENT OF LOW BACK PAIN *

Bernard M. Halbstein, M.D., Long Branch, N. J.

Proper consideration of the operative treatment of low back pain must, of necessity, include the accompanying symptom of sciatica. Otherwise most of the patients and probably the most important group of conditions would have to be eliminated from the discussion. The average general practitioner and surgeon are most anxious to know the indications for operative intervention in low back pain, what the length of disability will be and what result can be reasonably anticipated. Orthopedic surgeons and neuro-surgeons who include surgery of the low back in their work still meet with great resistance when surgery is proposed. Patients and even some general practitioners have a preconceived idea that the result of surgery will always be poor and they shy away from it. This attitude is not completely unjustified, because strict indications are not always completely adhered to by all operating surgeons. Poor results get the most publicity and are used by those needing surgery as a criterion for operations in general. To dispel these fears, a better understanding of the proper operative management of low back pain and sciatica is needed, which is the aim of this paper.

With the discovery of the role of the herniated nucleus pulposus, a complete revision has come about in the concept of the treatment for and mechanism of low back pain and sciatica. There has been an upswing in the number of operations performed and a corresponding increase in the number of people relieved of their symptoms by properly carried out surgery. We are still in the midst of a trend. The final answer has not yet been attained in the treatment of these low back problems. We know today that many of the sacro-iliac and chronic lumbo-sacral strains and "lumbagos" of yester-year were really disc herniations. We have lived through the era of sacro-iliac fusions, tri-sacral fusions, and lumbo-sacral fusions performed in the leading hospitals in this country. The search for the truth in this complex problem has led to a great deal of trial and error, with such operations as pyriformis muscle section, stripping of the soft tissues over the sacro-iliac joint, resection of the fascia lata, and so forth. Most of these operations have been discarded today, but many had shown merit in past years. Actually they were successful in treatment of secondary pathologic processes invoking symptoms. Today we are more prone to treat the primary underlying pathologic process, generally the herniated disc before the secondary muscular or ligamentous contractures can occur. Even in surgery of the herniated disc today there is no agreement among operating surgeons as to the indications, time of surgery, technic, whether disc removal should be combined with fusion, and the post-operative management of the patient, including immobilization. We certainly have no panacea. Extreme care must still be used when surgery is indicated for the treatment of low back pain. The surgeon who associates the diagnosis of the herniated nucleus pulposus with an automatic indication for operative treatment will get a high incidence of poor results. On the other hand, the surgeon who adheres to strict indications and uses his surgical ability as a privilege on a select few will get a high ratio of good results.

Let us consider how we select cases amenable to operative treatment.[1] The importance of a *thorough* history and physical examination cannot be too strongly re-emphasized. We must be aware of such congenital anomalies as spondylolisthesis and spondylolysis and the lumbo-sacral variations coming under the general heading of unstable lumbo-sacral joint. There are the infections, such as osteomyelitis

* Read before the Section on Orthopedic Surgery at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1952.

1. Postgraduate Lectures on Orthopedic Diagnosis and Indications, Arthur Steindler, M.D., C. C. Thomas, 1951, Springfield, Illinois.

and tuberculosis. There are metabolic conditions such as rheumatoid and hypertrophic arthritis. We keep in mind such conditions as the Charcot joint, Paget's disease and metastatic carcinoma, as well as intraspinal tumors, such as neurofibroma, meningioma and hemangioma. A proper recognition of some of these conditions will steer us away from surgery. This will not only increase the ratio of good results, but will eliminate much needless and wasted surgery. Proper surgery specifically directed at others of these conditions will serve to correct the underlying pathologic defect and the results should be good. This is especially true in the spinal fusion treatment of spondylolisthesis, the unstable lumbo-sacral joint and in certain instances of arthritis. The value of internal fixation by spine fusion of the diseased segments in Pott's disease is well known. Excision of circumscribed and removable intraspinal tumors is dramatic in its relief of symptoms. Finally we come to the herniated nucleus pulposus, known also as ruptured disc, herniated disc, prolapsed disc and by many other names. This differential diagnosis is by no means a comprehensive one but will serve the purpose in this discussion.

Most of the conditions mentioned above have been subjected to surgical treatment at one time or other and they probably always will. The first important point is that, wherever possible, a *correct* diagnosis be made. Next in importance is a thorough trial of conservative treatment. This applies to the herniated disc as well as to the other conditions. This is emphasized because we are at the crest of a wave of enthusiasm for the operative treatment of herniated discs. Today it is actually more important to know when not to operate than when to operate. Failures of conservative treatment and recurrences of attacks lead us to think of surgery, but sound judgment is needed in a proper evaluation of all factors involved. The patient's emotional and physical make-up must be properly evaluated, as well as his age, duration of symptoms, the question of legal and compensation claims and an evaluation of the adequacy of conservative treatment. Patients past middle age and those with litigation complicating their condition are poor operative risks in general. Many times on first seeing a patient who has presumably had adequate conservative therapy, one would do well to repeat a conservative trial, to be satisfied that conservatism has failed. Patients with anomalous conditions of the low back (such as the unstable lumbosacral joint and spondylolisthesis) are, by and large, relieved by the use of a back support. Spinal fusion cannot be depended upon for success in these conditions unless relief is obtained by back support. Most degenerative and arthritic conditions of the low back remain out of the realm of surgery according to present concepts. The mechanisms involved producing the symptoms are often very complex and may even be multiple. One condition may be the factor which produces pain, while an associated condition may have sufficient x-ray findings to mask the condition producing the pain. This is especially true in the disc syndrome where there may be an associated spondylolisthesis; thus poorly applied operative treatment might include the one and not the other.

The disc syndrome makes up the majority of conditions causing low back pain and sciatica. We find ourselves at the point where a given patient has had a failure of adequate conservative treatment and probably recurrences of attacks. He must now choose between a future of semi-invalidism, (or at least greatly reduced activities) or attempted relief by surgery. One says *attempted* relief because, as with any other type of surgery, no promise or guarantee of cure can be given. The facts must be presented fairly to the patient and he must enter into the planning of the operation with the surgeon. Having had proper x-ray studies and general laboratory and clinical work-up, a myelogram should be done. Some authorities assert that an operation for disc removal should not be performed during the first attack. Others feel that surgery can be indicated in a first attack but not until at least six weeks of conservative treatment has failed to give relief. These rules are good in their general applications but of course exceptions can be found in certain cases of unrelieved nerve root pressure with unchanging or increasing neurologic findings, unrelieved symptoms, and especially when there is increasing evidence of

muscle weakness. Surgery should not be delayed here. Foot drop or toe drop constitute criteria for immediate operation. These cases are generally found to have, on operation, an extrusion of the disc material or a large protrusion which is quite firm and immobile. Evidences of unremitting nerve root pressure will be found to produce some or all of the well known, cardinal symptoms and objective findings. These are the aggravation of sciatic radiations by coughing, sneezing and straining, persistent numbness along specific dermatomes, reduced or absent deep tendon reflexes, well defined hypoesthesias and anesthesias along the same dermatomes that gave subjective symptoms, and the increasing muscle weakness determined by functional testing of these muscles. Earliest muscle weakness can be detected in the extensor muscle of the great toe which then progresses to the other toe extensors and finally to the extensors and flexors of the ankle. Persistence of marked restriction of straight leg raising is a fundamental and constant finding associated with unrelieved nerve root pressure.

There are differences of opinion regarding the necessity for routine myelography but it is considered by our group to be a most important preliminary to the operation. Properly performed, it can be done without harm to the patient and will yield important information regarding the multiplicity of lesions, the size and location of a protrusion and will differentiate the occasional intraspinal tumor which can simulate a disc in its symptomatology. A nearly complete removal of the pantopaque can be performed, except in a few instances. In these instances it has not been shown to do any harm in our series. Having localized the disc herniation by myelography, the operation is planned, with thorough preparation for blood transfusion during surgery. The operation is done under general anesthesia, using an intratrachial tube.

The technic of herniated disc removal has been fairly well standardized after its evolution from the complete laminectomy and transdural approach. At present nearly every surgeon removes the disc through the inter-laminal route with removal of portions of the adjoining laminae by means of a rongeur. Many surgeons have become adept at the removal of the herniated disc through a small incision with exposure of only the one side. Others prefer a wider exposure in order to follow the nerve root down to its exit from the foramen with an adequate look at the caliber of the foramen. We prefer operating with the patient in the prone position. Some prefer the lateral recumbent position with the surgeon seated. We feel that it is necessary after removal of the herniated portion of the disc to remove all loose fragments of disc material from within the confines of the intervertebral space. With the aid of pre-operative myelography it is sufficient to explore only the involved space. Without myeloggraphy it is probably safer to explore both the fourth and fifth interspaces on the side involved.

The question of spinal fusion accompanying the removal of the protruded disc material has been taken up in advance. It is now considered unnecessary by many observers to perform a routine fusion on these patients. Instability of the spine sometimes makes it a desirable procedure, however, since the removal of the herniated disc material can be expected to relieve the root irritation and therefore the sciatica; but it cannot be expected to relieve the backache if there is accompanying vertebral disease causing instability. The argument for accompanying spine fusion is that it takes less than forty-five minutes additional operating time and only about ten days more of hospitalization and one has greater assurance of a stable spine in addition to the relief of nerve root pressure.

The technic of spinal fusion in our hands at present consists of a modification of the Hibbs fusion with the addition of an H graft from the ilium locking the spinous processes. The Hibbs portion of the fusion consists in the removal of the cartilage from the articular facets and the turning up and down of bony chips from the laminae, removing some of them and removing chips from the surface of the sacrum. These are broken up into smaller bits and laid across the area to be fused. The H graft is inserted between the spinous processes and locked while the patient is in the flexed posi-

tion so that by extension it serves to keep the vertebrae apart and the disc space from collapsing. Often in performing a lumbo-sacral fusion the spinous processes are close enough together so that the spinous process of the fourth lumbar vertebra can be used as an H graft for the lumbo-sacral joint.

The argument against spinal fusion accompanying the disc operation, is that a sufficient number of patients get relief from disc removal alone to obviate the necessity for subjecting them to additional surgery; and that spinal fusion should be an operation performed on its own merits. Proponents of disc surgery alone state that it is preferable to have the small proportion of patients who persist with their low back pain return for a second operation, since the majority of patients will not need it. We have found this to be true, particularly since any residual back ache that patients may have can still be subjected to ordinary conservative treatment with success, just as it would have succeeded were they treated without the complication of the disc protrusion.

Routine spinal fusion of necessity has its complication of pseudo-arthrosis requiring reoperation, which is eliminated in large measure by performing the operation less frequently. One group of observers[2] found pseudo-arthrosis in not less than 20 per cent of a large group of spinal fusions. The incidence of pseudo-arthroses is smallest when a lumbo-sacral fusion is performed; but is greater when the third or fourth lumbar vertebrae are included in the fusion area. Our experience has been with a group of patients on whom we have performed routine spinal fusions as an accompaniment of their disc operation for a period of at least four years. In the last three years we have changed to the disc operation alone, using spinal fusion only when an estimate could be made of a very unstable lumbo-sacral joint or markedly narrowed intervertebral disc space. The operation of disc removal alone in this select group of patients has given very satisfactory results. It is most gratifying to both the patient and the surgeon. Hospitalization need not be prolonged and patients are now allowed sitting and out of bed at the end of the first week. We like to apply a light canvas corset when the patient is first permitted to get up. He is generally ready to leave the hospital on the tenth day. Soon after discharge, however, the patient is asked to return for rehabilitative exercises, under the supervision of a trained physical therapist, so that proper tone, flexibility and strength can be restored to the back and leg musculature. This aids the patient in resuming his former occupation with psychologic and physical encouragement and with the least likelihood of subjecting himself to further strain. We advise that patients wear the canvas corset until, by reason of the exercises, they are able to bend over and touch the floor with ease. Instructions in the proper way to lift heavy objects and to use the back with the minimum of strain are important. We also consider it important to urge patients who have been doing work favoring back strains, to try to change their occupations. This can be accomplished much more frequently than would be expected. Patients are perfectly willing to do so on medical advice. Some recurrences are avoided by this advice. If spinal fusion accompanies disc removal, patients are kept in bed for approximately three weeks, after which they are ambulatory with a light plaster corset. They avoid all types of strenuous activity but are placed on a regimen of therapeutic exercises. At the end of three months, functional x-rays are taken of the lower spine to determine the status of the fusion. These are taken with the spine in flexion and extension and in right and left lateral flexion which, when superimposed, show the stability of the fusion. When the fusion can be considered stable, forward flexion exercises are added to the regimen and external support may be discarded. These patients are all kept under some type of supervision up to a six months' post-operative period, prior to discharge.

According to Barr,[3] the causes of failure in the operative treatment of disc lesions fall into five categories. These are wrong or incomplete diagnosis, delay in treatment, poor selection of cases, surgical risks and complications, and poorly supervised after-care. Wrong or incomplete diagnosis includes the treatment of the

2. Cleveland, M., Bosworth, D. M., and Thompson, F. R.: Journal of Bone and Joint Surgery, 30:302 (April 1948).
3. Barr, Joseph S.: Journal of Bone and Joint Surgery, 33:633 (July 1951).

skeletal condition without the recognition of the intervertebral lesion and so forth. The "delay in treatment" category includes patients who have already had irreversible changes in the nerve root causing actual muscle paralysis or weakness, or permanent sensory disturbances which will not recover after the removal of a herniated disc. A poor selection of cases will obviously cause failures in expected results, just as it will in any other condition in any field of surgery. Surgical risks and complications will of course be minimized according to the abilities of the operating surgeon. However, even in the hands of the best technician light retraction of a nerve root will, in some cases, result in muscle weakness; and the ordinary risk of anesthesia and post-operative complications, such as pulmonary embolism must be kept in mind. Poorly supervised aftercare is a large factor and is much less likely to occur in the hands of orthopedic surgeons than neuro-surgeons, since the orthopedist is more likely to be "rehabilitation-minded". These patients need the stabilizing influence of follow-up care for its psychologic and physical effect; and they have consistently done better with a properly managed post-operative routine.

SUMMARY

The treatment of low back pain with or without sciatica is, in most instances, conservative in nature. With failure of conservative treatment or in cases of recurrent symptoms, surgical treatment should be resorted to as an alternative to greatly reduced activity or a life of semi-invalidism. Certain findings in the examination make it advisable to operate even at first examination of the patient. These include major demonstrable muscle weaknesses and unrelieved nerve root pressures. Spinal fusion should be reserved for the surgical treatment of the skeletal defect when conservatism has failed. As an accompaniment of disc removal it should be indicated on its own merits, rather than be used as a routine. With a proper selection of case material and proper surgical management, including pre-operative, operative and post-operative, the expected result is satisfactory and most gratifying to both the patient and the surgeon.

DISCUSSION

P. J. Finegan, M.D.: Dr. Halbstein has rendered the task of discussing his paper an easy one in that he has presented an excellent and most comprehensive outline of the up-to-the-minute views of the great majority of the orthopedic surgeons in this country and abroad. I would emphasize his statement that surgery of the spine as an answer to many of the perplexing problems of low back pain has gradually emerged from the "cloak and dagger" phase and that now the patient seeking relief may approach the surgeon with less trepidation than heretofore.

Experience has sobered the enthusiastic zeal formerly exhibited by many of the pioneers in this field. Better criteria for judgment have evolved to aid in interpolating the application of general rules of diagnosis and treatment in the individual case of low back pain.

Dr. Halbstein has presented the facts concerning why, how, when and when not to exhibit surgery for the relief of low back pain. Seventy per cent of all back pain patients are first seen by the family doctor and it is our hope that the discussion here today will aid those of you who are not engaged in orthopedic surgery in properly advising such patients as to what may be done for them and what they may expect if the question of surgery is advanced.

Physicians in practice prior to the advent of widespread disc surgery have naturally posed the question as to how the patients suffering from disc disorders have managed to survive without surgery. Some, as the author has indicated, were doomed to a life of chronic invalidism. Others gradually recovered and were able to resume normal activities without appreciable disability, with conservative treatment. This can be understood when one realizes that prolapse of the intervertebral disc usually occurs in one of two ways. A healthy or degenerated disc may be suddenly extruded as the result of violence in one of several ways. Such an extrusion is likely to be considerable in amount and cause great pressure on the contents of the spinal canal with very severe symptoms and total incapacity until relieved by eventual disintegration of the extruded material in the absence of surgery. The less extensive extrusion in degree and time of the spontaneously prolapsed disc, in the absence of external violence, will, by the progression of the original degeneration factor, tend to exert a self-limited influence and lead to complete, or nearly complete, quiescence. Low back pain may or may not be due to a prolapsed intervertebral disc. If a disc be at fault then a careful history and thorough clinical and laboratory examination along the lines indicated by Dr. Halbstein will determine the proper approach to relief in the individual case.

263 Bath Avenue

ANTIBIOTICS IN PEDIATRICS *

B. M. Kagan, M.D., Chicago, Illinois

There is a significant difference in antibiotic therapy in pediatrics as compared to adult medicine. We have been interested in the possibility for simplification of the conditions for choice of the various antibiotics. There are infections with certain groups of organisms which the well known antibiotics do not touch. Particularly impressive is the efficacy of the newest of the available antibiotics — that is Polymyxin B — in the treatment of one of these infections, the Pseudomonas or pyocyaneus infections. It is these three areas which I should like to discuss.

First, consider the differences between antibiotic therapy in infants and children and that in adults. Before the days of sulfonamides and antibiotics, it was important to know whether a patient had meningitis or pneumonia because therapy depended upon the part of the body affected. Today it is more important to know whether it is a meningococcus or a pneumococcus which is causing the damage. Today it is important to know the area of the body affected, mostly because it gives us an idea as to the organism which is probably causing the damage. Thus one of the main differences between antibiotic therapy in infancy and childhood and that in adults brings us to one of the principal differences between pediatrics itself and internal medicine. There are marked differences in the causes of the various clinical entities in different age groups. Meningitis in the premature infant and the newborn is caused mostly by Bacillus coli. For meningitis in this age group, therefore, at least until the bacteriologist reports on the culture, one of the ATC drugs (Aureomycin, Terramycin, or Chloromycetin) would be the drug of choice. On the other hand, meningitis between 1 and 3 years of age is most likely due to the influenza bacillus, in which case, Chloromycetin appears to be the drug of choice. Over 3 years of age, meningitis is most often caused by the meningococcus, in which case sulfonamide with or without penicillin would be the therapy of choice.

Thus today, knowledge of the most likely causative organism is very important. Here is another example: septicemia in an infant with jaundice means that the affecting organism is most likely a B. coli or a staphylococcus because septicemia due to other organisms, such as streptococci or pneumococci in this age period is usually not associated with jaundice. It follows that in sepsis with jaundice in the infant, Aureomycin or Terramycin would be the drug of choice; in sepsis without jaundice in infancy, the streptococcus or the pneumococcus would be the most likely invader and penicillin the drug of choice.

Again osteomyelitis in infancy is most often caused by streptococci, in which penicillin would be the preferred drug. On the other hand, later in childhood the staphylococcus is the most common organism in osteomyelitis, in which case Terramycin or Aureomycin would be the drug of choice. We could go on with other examples showing that the approach to antibiotic therapy in infants and children is significantly different because of the known differences in etiology of the various clinical infections in different age groups.

Particularly in children the mode of administration is important. Whether an antibiotic is a drug of choice in some children, depends upon whether the child will accept it — as any practicing physician knows. Its taste and the frequency with which it has to be administered are important considerations. The new amphoteric forms of Chloromycetin and Terramycin have made them much easier to administer to children.

In general, reactions to these drugs are less common in children than in adults. Interesting, however, has been the occurrence of fever due to the antibiotics. It is infrequent but may be very confusing. There used to be a time when one of the major functions of a pediatric con-

* From the Kunstadter Laboratories for Pediatric Research and the Department of Pediatrics, Sarah Morris Hospital for Children of Michael Reese Hospital, Chicago, Illinois. This paper was presented before the Essex County Medical Society, Newark, New Jersey, April 10, 1952.

sultant was to find the otitis media which had not been previously observed. Now one of his major duties is to discontinue the antibiotics which have been given for fever of undetermined origin. I hasten to add that this is an exaggeration of the frequency with which such fever is observed. But I have seen it often enough so that it merits calling to your attention.

During prolonged administration of some of the antibiotics, the occurrence of fungus infections in children has become a real problem. In cystic fibrosis of the pancreas where Aureomycin or Terramycin are given for long periods of time, even mycotic endocarditis has been observed.

Herbert Spencer once said, "When a man's knowledge is not in order, the more of it he has, the greater will be his confusion". This was the situation in the antibiotic field a short time ago. You will no doubt recall the many tables showing the various diseases and the drugs of choice, first, second, third, et cetera. There was so much information that it was hard to keep track of it. However, there was just not quite enough information to make order out of it and hence the confusion. By now, however, it has become clear that the broad spectrum antibiotics (which in our department we have gotten into the habit of calling the ATC drugs), Aureomycin, Terramycin, and Chloromycetin, have a range which is very similar one to the other. In most conditions the choice among them is based not so much upon the superiority of one over the other for the particular group of bacteria but more upon acceptability by the patient, freedom from reaction, and the individual patient's sensitivity. Twenty-four or 48 hours later, however, the choice of drug may be changed depending upon the sensitivity of the specific infecting strain to the various antibiotics as indicated by *in vitro* tests in the laboratory. When one sees the patient for the first time, however, and makes the clinical diagnosis, there is usually little basis for choice among the 3 drugs other than personal familiarity and the points already mentioned. Furthermore, it seems clear that the *in vitro* tests are themselves not always reliable guides to the most effective drug, and therapeutic trial becomes the final test.

There are only a few exceptions to the overlapping range of usefulness of these ATC drugs — notably in typhoid fever where Chloromycetin appears to be the drug of choice; in staphylococcal infections where Aureomycin or Terramycin are preferred. Then there are the infections where the other antibiotics are outstandingly superior such as in meningococcus infections where sulfonamide and penicillin have the advantage; in beta-hemolytic streptococcal infections where penicillin is superior; in streptococcus viridans infections where a combination of penicillin and Streptomycin has proved most effective; in tuberculosis where Streptomycin and PAS or other adjuvant or where the new drug, isonicotinic acid and similar compounds, appear to offer much hope.

The third area of particular interest has been the groups of organisms for which we have until recently had no specific therapy. Of these, three are important in pediatrics. First are the pseudomonas or pyocyaneus infections, second proteus, and third the fungus infections. For proteus and fungus infections we still have no really effective therapy. For pseudomonas infections one of the most recently available antibiotics appears to be a powerful agent. That is, Polymyxin B.

Polymyxin B is derived from Bacillus polymyxa. Five distinct antibiotics have been derived from it and are designated A through E.

Polymyxin D was the first form described and was used in most of the early clinical reports. Renal toxicity was observed and the use of Polymyxin D was discouraged. This experience with one derivative unfortunately prejudiced many workers against all the Polymyxins. Polymyxin A (Table I) was discovered at about the same time. Polymyxin B and E were discovered two years later and it is these forms with which we have worked.

The Polymyxins differ from each other in amino-acid composition. There has been some consideration that the presence of serine in the molecule of Polymyxin D accounts for its renal toxicity. However, there has been little evidence of renal toxicity when the newer derivative, Polymyxin B, has been used.

Table II shows some of the characteristics of the Polymyxins. They are bactericidal. This is in contrast to the other new antibiotics such as the ATC drugs which are primarily bacteriostatic. Its bactericidal action is rapid. Probably as a result, resistant strains do not tend to develop.

Our data show that by *in vitro* tests, Polymyxin B is more effective than Streptomycin; and the data of Finland and his associates show that it is more effective than Aureomycin or Chloromycetin against B. coli, aerobacter aerogenes, and pseudomonas.

Orally we gave 2 milligrams per kilogram of body weight every 4 hours. When given by mouth, no detectable level is found in the blood. Intramuscularly we gave a dose of 0.8 milligrams per kilogram every 4 hours. More recently, particularly in less serious infections and in urinary infections we have used a maximum dose of 2.5 milligrams per kilogram per day divided into 4 doses. Very high levels are obtained in normal patients' urine when the drug is given intramuscularly and good blood levels can be maintained.

Table III shows the results of treatment of 18 children with urinary tract infections. Polymyxin was successful in 11 when other antibiotic therapy had failed. Failure to achieve success with any of the drugs in at least 3 of these children seemed due to our inability to relieve serious obstruction in the urinary tract.

We found Polymyxin B to be quite effective in Shigella and pseudomonas infections of the gastro-intestinal tract when given by mouth. Florman and Schifrin gave Polymyxin B orally to one infant with diarrhea due to pseudomonas. This infant had had diarrhea in the hospital for 15 days. They noted that within 24 hours of beginning therapy, the infant was clinically improved and in 4 days the stool was free of pseudomonas. In general this has been typical of our experience also. There have been a few cases, however, where in spite of clinical improvement, we have either not eliminated the organism or it reappeared after therapy was stopped.

TABLE I

POLYMYXINS

Form	Synonym	Discoverer	Year	Amino Acid Differences: Phenylalanine	Serine
Polymyxin D		Stansly et al.	1947	—	+
Polymyxin A		Ainsworth et al.	1947	—	—
Polymyxin B	Aerosporin	Brownlee et al.	1949	+	—
Polymyxin C		Brownlee et al.	1949	+	—
Polymyxin E		Jones	1949	—	—

Diaminobutyric acid, threonine and fatty acid 6-methyloctanoic acid ($C_9H_{18}O_2$) present in all.

TABLE II

POLYMYXIN — CHARACTERISTICS

ANTIBIOTIC

- Bactericidal (about 10 times Streptomycin)
- Rapid action
- Resistant strains produced only with difficulty
- Gram negative bacteria—almost exclusively

CHEMICAL

- Basically—polypeptide plus fatty acid
- Molecular weight 1000 - 1300
- Stable indefinitely in dry state—room temperature
- Stable in solution in refrigerator—2 weeks
- Standard—10,000 units/mg. dry weight

TABLE III

POLYMYXIN B

URINARY TRACT INFECTION

Organism	No. Patients	Results
E. coli	7	4 sterile after 5 days 3 not effective
A. aerogenes	4	4 sterile after 5 days (1 relapsed)
Ps. aeruginosa	5	3 sterile after 5 days (1 relapsed) 2 not effective
Mixed:		
A. aerogenes Ps. aeruginosa	2	Not effective

One of our patients was a 12 year old child with a pseudomonas infection of the gastro-intestinal tract. He was given the drug orally and intramuscularly. This was a physician's son who had a pure culture of pseudomonas grown from his gall bladder. He had been chronically ill for several years. At the time we started Polymyxin, he was critically ill. The 4 physicians, including his father, who were responsible for his care were in doubt as to whether he could recover. He had had fever of 101 to 104 for some weeks. Stools revealed pure cultures of pseudomonas. On the third day of therapy, he was afebrile and clinical improvement was marked. On the seventh day of therapy stool cultures revealed no pseudomonas. Clinical improvement was gradual and at the present time, about three years later, he is apparently well.

During the past two years we have come to appreciate the importance of pseudomonas in gastro-intestinal infections more than we had previously been aware. Frequently, we have noted it as the only possible pathogen in diarrhea. At other times we have observed it in small infants whose clinical manifestations were only distention and ileus. Formerly, we were inclined to think that this organism was merely a secondary invader. However, since we have had experience with Polymyxin in eradicating it, we are more impressed with its possible pathogenicity. Often within 24 to 48 hours the clinical condition is much improved. Within 4 to 7 days the organism is often eliminated from the gastro-intestinal tract. We have found relapse much less likely if the drug is given for at least 7 days. Before the availability of Polymyxin B, Shaffer and Oppenheimer reported observations which were similar as to the possible pathogenicity of pseudomonas. They also pointed out that treatment with penicillin appears to stimulate the growth of pseudomonas by killing off antagonistic organisms. Of particular interest is a series of 5 infants they reported who died of ulcerated appendices, several of which had perforated. The microscopic picture of all of these ulcerations was similar. The tissues appear to have been killed without the evocation of an inflammatory response. This absence or almost complete absence of polymorphonuclear invasion was associated with the finding deep in the necrotic tissue of swarms of Gram negative bacilli. In all of these cases pseudomonas had been demonstrated in the stool, blood, or spinal fluid.

We are familiar with at least 14 patients for whom Polymyxin B has apparently been life saving. It has been apparently life saving for 4 patients with influenzal meningitis, 2 we observed, one observed by Brakeley in the Mountainside Hospital in Montclair, N. J., and one by Swift and Bushby in England. However, in this condition, at least 3 other antibiotics are generally effective; and the frequency of toxicity with them is lower than with Polymyxin. We have therefore used Polymyxin in influenzal meningitis only when the others have failed.

However, none of the other antibiotics are as effective either clinically or by *in vitro* tests against infections due to pseudomonas. We have observed one case of pseudomonas meningitis for whom the drug was apparently life saving. Schoenbach reported 3 such patients. Hayes and Yow reported another and Jawetz recently reported 2 more.

Wallerstein reported a septicemia due to pseudomonas in an adult in which the drug was apparently life saving. We observed an infant with pseudomonas septicemia and urinary tract infection which cleared under the influence of this drug. We observed one older child with a pseudomonas infection of the gall bladder and gastro-intestinal tract whose life appears to have been saved by the use of this drug.

In our studies, Polymyxin B has been associated with very little evidence of renal toxicity. This has also been the experience of Jawetz on the west coast, Pulaski in Texas, and Kaplan and co-workers in New York.

Intramuscular injection of the drug is associated with a moderate amount of local pain in a number of cases. This is alleviated somewhat when it is injected with procaine. We have noted in about a third of the children moderate to marked degrees of lethargy, irritability, and anorexia beginning about the second or third day of intramuscular therapy. These symptoms improve in spite of continuation of therapy in most cases and clear completely soon after the drug is stopped.

A few children developed urticaria or some flushing of the face. These were alleviated considerably by antihistaminic drugs. The most serious evidence of toxicity we observed was ataxia. This developed in one child receiving Polymyxin B intramuscularly and cleared within 24 hours after the drug was stopped.

Observations in our hospital suggest that the frequency of toxic signs due to this drug in adults may be considerably higher than in children. These signs in adults are mostly neurotoxic rather than renal. The adults, for example, complain of a feeling of having had a "close shave". They also develop paresthesias of the hands and feet.

In Polymyxin, therefore, we do not have a drug with the wide therapeutic usefulness and safety of penicillin. It might, however, be compared to Streptomycin except that with Streptomycin some of the manifestations of toxicity have been permanent whereas with Polymyxin B they have thus far always been reversible. It can be given safely by mouth for gastroenteric infections; it is not absorbed. It is useful primarily in infections due to Gram negative bacilli which do not respond to other antibiotics. It is the most useful drug available in infections due to pseudomonas. The signs of toxicity are not so severe as to preclude its use and thus far have been reversible. Where it is clearly indicated, Polymyxin can be life saving.

We have obviously touched on just a few areas of current interest in the application of antibiotics in pediatrics—stressing particularly significant differences in pediatric use as compared to that in adults; the possibilities for simplification in the choice of antibiotics and the present status of one of the newest of the available antibiotics—Polymyxin B.

MICHAEL REESE HOSPITAL

TREATMENT OF CARDIAC ARREST[1]

Cardiac arrest amenable to treatment occurs rarely, but because it can be handled successfully every physician should be prepared for such an emergency. Most cases occur during operations or just after an anesthetic has been started. Even as minor a procedure as applying an anesthetic agent topically may precipitate cardiac stand-still.

The first and most important thing to realize is that when a patient's heart stops beating it must be resuscitated within three to five minutes or the brain will have sustained irreparable anoxic damage. Diagnostically the patient suddenly loses consciousness, respiration ceases, and becomes pulseless. Two things must be done instantly: artificial respiration or ventilation with an anesthesia machine must be started, and the heart must be massaged. The heart can be approached through the diaphragm if an abdominal operation is under way, or the chest should be opened quickly via a lateral incision through the fourth or fifth intercostal space anteriorly. Bimanual massage at a rate of 60 to 80 per minute should be instituted at once. Less important and less urgent measures are injection of five or ten cubic centimeters of 1:10,000 epinephrine solution into the cavity of the right auricle or ventricle if the heart is in asystole, or five cubic centimeters of 1 per cent procaine solution if there is ventricular fibrillation present. Later intravenous or intra-arterial infusions can be given to increase blood volume.

Here are a list of DON'Ts to be followed in this emergency:

1. DON'T listen for a faint heart sound.
2. DON'T wait for an electrocardiogram.
3. DON'T inject epinephrine through the chest wall into the heart.
4. DON'T dilate the rectal sphincter.
5. DON'T give mechanical respiration by compression of the chest.
6. DON'T give a blood transfusion.
7. DON'T give an intra-arterial transfusion.

1. Editorial: When the Heart Stops Beating. General Practitioner (September 1952).

DYSPHAGIA, PSYCHO- OR SOMATIC?

FERDINAND G. WEISBROD, M.D., East Orange, N. J.

Most gastro-intestinal symptoms can be of either emotional or organic origin. Dysphagia, (difficulty in swallowing) however, is almost without exception associated with pathologic changes, the level of which can be located by the patient himself in most instances. Even in cardiospasm, somatic abnormalities are easily demonstrated in the esophagus. Dysphagia should not be confused with globus hystericus which is always of emotional origin. Globus hystericus is the sensation of a lump in the throat, not affected by swallowing. In typical globus, food can be taken without difficulty.

Emotional dysphagia must be exceedingly rare. In World War I, for instance, no such cases were seen in soldiers,[1] although hysterical aphonia and vomiting were observed rather frequently. Many patients with emotional dysphagia actually make no attempt to swallow. Thus in any patient complaining of difficulty in swallowing a functional diagnosis should not be made unless satisfactory roentgenologic films and, perhaps, esophagoscopy have been included in the diagnostic study. Esophagoscopy is essential since the inability to use compression during x-ray studies of the esophagus may easily result in missing a lesion.

Case 1: A 38-year old white female had a history of dysphagia for eighteen months. Following an operation for intestinal obstruction, a rubber nasal tube was used for intestinal decompression and left in place for three weeks. Soon after its removal dysphagia was first noted. Initially there was marked weight loss, but later she was able to take food in a finely divided state. She soon regained her normal weight level. Meal time was always a protracted session. Once, she swallowed a portion of a nut that lodged in her esophagus and was not regurgitated for 2 weeks. The patient could point out the exact spot where the nut and the food she ate would "stick."

X-ray studies had been negative and during the eighteen months of discomfort she had almost been convinced that her symptom was of emotional origin. Second films including the use of a thick barium paste, were also negative. When a barium soaked pledget of cotton was swallowed, however, the point of obstruction was demonstrated in the lower portion of the esophagus. The cotton pledget would not pass through the stricture and had to be removed through the esophagoscope five hours later. At this time the smallest esophageal bougie, (No. 8 French), could not be passed. The mucosa was reddened and inflamed in the conical narrowed area just above the stricture. After twelve weekly dilatations through the esophagoscope the lumen was increased to a size 26 French bougie, and the patient was eating so well that she refused any further treatment. When last heard from (one year later) she was eating without difficulty.



Figure 1. Case 1. Barium-soaked cotton pledget (X) impacted at stricture site in lower esophagus with dilatation proximally.

The long intubation period with the irritating rubber tube provoked an inflammatory reaction that resulted in a benign esophageal stricture during the healing process. It would have been much less irritating to have used a

1. Hurst, Arthur: Journal of Laryngology and Otology, 58:60 (February 1943).

plastic tube instead, and thereby avoid the sequela. The failure to demonstrate the lesion by a routine radiologic study emphasizes the need of simulating the patient's normal eating habits. Thus a barium-soaked pledget of cotton or bread, or better yet, a barium-filled medicinal capsule should be swallowed by every patient with dysphagia during roentgenologic investigation. Negative findings on an incomplete study of this patient's difficulty resulted in her being considered a "functional case" and caused her eighteen months of unnecessary distress.

Case 2: A 46-year old white male had a history of gradually increasing dysphagia for 3 months. This was associated with regurgitation of food occasionally, but no weight loss. He could tell at what point "the food would hang up." First films were reported "negative." The patient was then referred for psychiatric treatment without an attempt at esophagoscopy. Because no improvement occurred on psychotherapy, sanitarium care was suggested, but declined. A month later, a burning sensation in the epigastrium was noted with radiation straight through to the back. X-rays taken a few weeks later showed a mass projecting into the gas bubble of the stomach with submucosal extension of the lesion into the lower esophagus. This was verified at esophagoscopy. An inoperable carcinoma of the gastric cardia extending around the aorta was found at surgery.



Figure 2. Case 2. Malignant mass extending into gastric air bubble (X) with submucosal extension into lower esophagus (arrows) causing dilatation of esophagus.

Again the failure to study the patient completely resulted in the missing of a gross organic lesion. The presence of the back pain was suggestive of the inoperability of the carcinoma. Accepting the diagnosis of "no organic disease," the psychiatrist attempted to cure this patient by psychotherapy!

Case 3: A 61-year old female had a history of progressive scleroderma of hand, face and neck dating back 6 years. At that time her left arm had been removed following a compound fracture. Five years later, she first noted dysphagia which gradually became worse in spite of cortisone therapy. Esophagoscopy revealed normal mucosa in a conical narrowed segment in the lower end of the esophagus. After four weekly dilatations through the esophagoscope, bougies were passed over a previously swallowed thread up to a size No. 42 French. Although the stricture is kept open with mercury-filled rubber bougies and food can pass through into the stomach, the patient still complains of a "sticking" sensation upon eating in the upper esophagus. This is due to the generalized involvement of the esophagus by the sclerodermatous process with the marked alteration of peristaltic activity as a result.

In this patient, the dysphagia was first ascribed to emotional causes even though scleroderma is notoriously associated with esophageal lesions.[2] The generalized nature of the lesion in the esophagus apparently was a factor in the inability of the patient herself to locate the level of the stricture. The failure of the cortisone to prevent the progressive course of her swallowing difficulty is also worthy of note.

SUMMARY

1. Dysphagia is practically never of emotional origin.

2. In its study, roentgenologic investigation may be inconclusive and esophagoscopy may be needed to make the diagnosis.

3. Three cases of dysphagia are presented

2. Hale, C. H., and Schatzki, R. R.: American Journal of Roentgenology and Radium Therapy, 51:407 (April 1944).



Figure 3A. Case 3. Film taken in February 1952 of scleroderma of esophagus with stricture (arrows).



Figure 3B. Case 3. Four months later after dilatation with bougies showing increased diameter of stricture, decreased dilatation above, but the generalized involvement of the esophagus in this condition preventing reversal to a normal functioning organ.

in which emotional diagnoses were made at some time during the course of the disease.

4. Two strictures of the esophagus, one benign following intubation for a long period and the other secondary to scleroderma, were successfully dilated with esophageal bougies.

5. A case of carcinoma of the gastric cardia with submucosal extension into the lower esophagus was inoperable by the time the diagnosis was finally made.

61 So. Munn Avenue

CLINICAL EVALUATION OF COMBINED DRUG THERAPY IN ACUTE UPPER RESPIRATORY INFECTIONS

ROBERT A. MCLANE, M.D., Hillsdale, N. J.

Acute infections of the upper respiratory tract represent the most frequent cause of human morbidity in the United States.[1] The common cold, presumably viral in origin,[2] and allergic states of the upper respiratory passages are often followed by secondary bacterial invasion which causes symptoms of varying severity for several days to several weeks. As Cheney has noted,[3] "many causes may provoke symptoms that are labelled the 'common cold' " . . . "if various remedies are combined judiciously and used discriminatingly in the individual case, surprisingly good results are obtained."

Objective of the present study was to compare the efficacy of certain combinations of drugs among patients who, on clinical examination, were found to be suffering from acute upper respiratory infections.

MATERIAL AND METHODS

Eighty-two patients were observed in this study. They included (1) workers in an industrial plant at Kenilworth, N. J., and (2) medical students and nurses at a medical school and a large municipal hospital in Washington, D. C.

Tablets of the following three drug combinations were tested:

(1) acetylsalicylic acid 150 milligrams, phenacetin 120 milligrams, and caffeine 30 milligrams.

(2) the foregoing "APC" mixture plus an antihistaminic agent (phenyl-toloxamine dihydrogen citrate 25 milligrams).

(3) the "APC"—antihistamine combination plus procaine penicillin G 100,000 units.

Tablets of all three drug combinations were identical in appearance and were identified only by code numbers.

In each case a history of the present illness was recorded on a standard form. One of three physicians, all following a uniform procedure, examined each patient and recorded subjective complaints and objective findings. White blood cell and differential counts were taken from random patients and the results also recorded. Known cases of nasal allergy (hay fever, vasomotor rhinitis) were excluded from the study.

Coded tablets of the various drug combinations were given alternately to patients with instructions to take two tablets about one hour before each meal, three times per day, until approximately 16 tablets had been taken. Each patient in the series reported daily for re-examination and progress notes were made of subjective and objective findings. At the end of 72 hours, the patient was again examined, white blood cell and differential counts were made, and the date recorded.

Cases of acute upper respiratory infection were classified according to the number and kind of presenting symptoms: fever, rhinorrhea, nasal and pharyngeal congestion (Table I). Cases were further classed according to the severity of symptoms (Table II). The dis-

TABLE I

Classification of Cases According to Number and Kind of Presenting Symptoms

Symptoms	No. of Cases
Nasopharyngeal Congestion and discharge *plus* fever	20
Nasopharyngeal Congestion *plus* fever	3
Nasopharyngeal Congestion and discharge	44
Nasopharyngeal Congestion	15
Total	82

TABLE II

Treatment Correlated with Symptoms

	Tablets APC	APC and Antihistamine	APC, Antihistamine and Penicillin
(27) Severe symptoms	4 or 24%	5 or 21%	18 or 44%
(34) Moderate symptoms	7 or 41%	11 or 46%	16 or 39%
(21) Mild symptoms	6 or 35%	8 or 33%	7 or 17%
(82) All Cases	17 or 100%	24 or 100%	41 or 100%

1. Buchan, *et al.*:Symptomatic Treatment of the Common Cold, Arch. Indust. Hygiene and Occup. Med., 4:32 (July 1951).
2. Topping, N., and Atlas L.: The Common Cold: A Note Regarding Isolation of an Agent, Science, 106:636 (December 26, 1947).
3. Cheney, M. C.: The Clinician and the Common Cold, GP, 5:47 (1952).

ease was considered *severe* if the temperature was in excess of 100 F., and if the patient had other symptoms of acute upper respiratory infection. The process was considered *moderate* when the temperature was less than 100 F. with only moderate congestion of the nasopharyngeal mucous membranes and moderate discharge. An infection was judged as *mild* when the patient was afebrile and had minimal objective signs of acute upper respiratory disease.

CRITERIA OF RESPONSE

The efficacy of treatment was measured on the basis of whether subjective and objective symptoms were controlled at the end of 72 hours following the initial visit. If no subjective or objective symptoms remained at the end of the observation period, the result was termed a *"complete cure"*. The result of treatment was called a *"failure"* if objective and subjective signs were unaltered or augmented despite the medication.

RESULTS

The results observed in the three treatment groups are summarized in Table III. Those patients receiving the tablet combining penicillin with "APC"—antihistamine showed a 72-hour complete or incomplete "cure" rate of 97.5 per cent, compared to a rate of 47 per cent in the "APC" treated group and 54 per cent in the group receiving "APC" plus antihistamine. These results assume more significance in favor of the penicillin-containing tablet when the severity of disease in each series is considered (Table II). Of the cases treated with the penicillin-containing tablet, 44 per cent were severe, as compared with 24 and 21 per cent, respectively, in the other groups. All severe cases treated with "APC" or with "APC" plus antihistamine were failures, while 56 per cent of the severe cases treated with the penicillin-containing tablet resulted in "complete cures".

In the severe cases, the initial total and polymorphonuclear leukocyte counts tended to be elevated and, after 72 hours' treatment with the penicillin-containing tablet, there was a tendency for the elevated total and polymorphonuclear counts to be lowered. However, no clear-cut correlation between the white blood cell counts and the response to treatment was discernible.

There were no objective signs of toxicity or unusual reactions noted in the eighty-two patients studied. Two patients discontinued the tablets because of complaints of "lightheadedness" in one case and nausea in the other, the former occurring in the "APC" control group. Other complaints, invariably mild and inconsequential, and not interfering with the course of treatment, included nausea and dizziness following the ingestion of the medication.

TABLE III

Effectiveness of Treatment

	Tablets APC	APC and Antihistamine	APC, Antihistamine and Penicillin
(27) Completely cured	1 or 6%	2 or 8%	24 or 59%
(34) Incompletely cured	7 or 41%	11 or 46%	16 or 39%
(21) Failures	9 or 53%	11 or 46%	1 or 2%
(82) Cases, total	17 or 100%	24 or 100%	41 or 100%

SUMMARY AND CONCLUSIONS

1. In a series of 82 patients presenting themselves for treatment of acute upper respiratory infections, including the common cold, 17 were treated with "APC" tablets, 24 with tablets containing "APC" and an antihistamine, and 42 with tablets containing the "APC"—antihistamine combination plus penicillin.

2. Of the patients treated with "APC" tablets, 53 per cent failed to improve after 72 hours. Of those treated with "APC"—antihistamine tablets, 46 per cent were not improved. In the group treated with the penicillin-containing tablets, there were only 2 per cent failures.

3. Based on described criteria of response, these results clearly indicate that a tablet containing aspirin 150 milligrams, phenacetin 120 milligrams, caffeine 30 milligrams, phenyltoloxamine dihydrogen citrate 25 milligrams, and procaine penicillin G 100,000 units, was most effective in relieving nasopharyngeal symptoms and preventing secondary complications in acute upper respiratory infections.

56 Oak Trail Road

INTERPRETATION AND REPORTING OF PROTHROMBIN ACTIVITY

INCLUDING A METHOD OF CONVERTING PROTHROMBIN TIME TO PERCENTAGE OF PROTHROMBIN ACTIVITY *

MILTON R. BRONSTEIN, M.D., Newark, N. J.

With the increasing use of anticoagulants for coronary thrombosis,[4] cerebral thrombosis, thrombophlebitis, frostbite,[3] and others,[5] there is need for a more concise understanding and interpretation of prothrombin activity as reported by various laboratories. The correct understanding and interpretation of the prothrombin time as one of the many tests in determining hepatic function as well as the response of the liver to parenteral and oral forms of the various vitamin K preparations are also essential.

It is the purpose of this paper to outline the procedure of a one-step prothrombin time determination used in many laboratories at present and include a method for the conversion of the prothrombin time in seconds to the percentage of normal prothrombin activity.

MATERIAL AND METHODS

In this study two thromboplastic substances, to be called A[1] and B, were utilized. Prothrombin determinations on serial dilutions of normal control plasma were performed with both thromboplastic preparations on 25 control bloods. The controls were all hospital personnel who had no complaints, had not had any type of illness in the previous three months and did not become ill one month after the determinations were performed. The hemoglobin of these controls varied between 80 and 95 per cent. Prothrombin determinations were within the expected normal range with both thromboplastic substances.

A total of over 1500 determinations was performed with each of the thromboplastic preparations. In addition to the controls as indicated above, the tests were done on patients on dicoumarin preparations, Dicumarol[2] and Tromexan† and also in the course of hepatic, gall bladder or hematopoietic system workups. Controls were run daily.

The method of prothrombin determinations performed is as follows:

Exactly 5 cubic centimeters of blood by venipuncture were obtained in a dry syringe and needle after the alcohol was wiped dry with a sterile gauze pad at the site of the puncture. The needle was removed and the blood put in a clean dry glass bottle which contained 2 drops of a 6 per cent ammonium and 4 per cent potassium oxalate solution. The blood was gently swirled three times in the bottle. If any difficulty was encountered in obtaining the blood, the procedure was immediately repeated.

Within a 30-minute period from the time the blood was withdrawn, it was brought to the laboratory and transferred to a test tube. The test tube was centrifuged for 4 minutes at 1500 revolutions per minute. The plasma was then pipetted off into another test tube and incubated for 3 minutes at 37.5° centigrade.

The thromboplastic substances were made as directed by the manufacturers and incubated at 37.5° centigrade for four minutes before using.

At this point, 0.1 cubic centimeter of plasma was placed into a dry clean test tube and 0.2 cubic centimeters of thromboplastin added. At the time both were placed together, a stopwatch was started. With gentle agitation (tilt-tube method) in a 37.5° centigrade water bath and continuous observation,

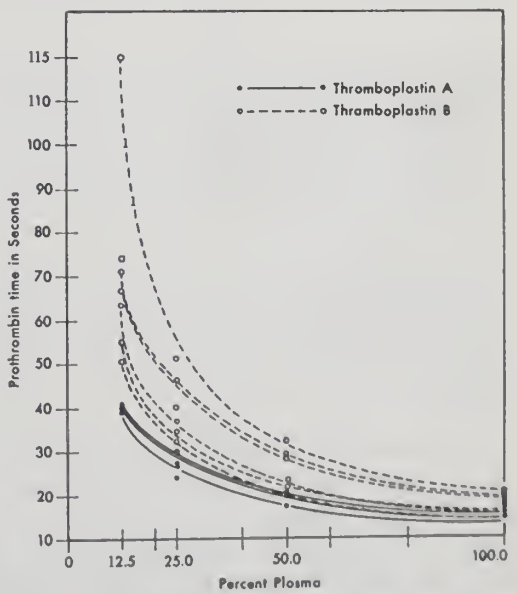


Figure 1—The prothrombin time in seconds of the various controls was plotted against the percentages of plasma dilution. Note that these curves are made of averages.‡

* From the Medical Department of the Newark City Hospital. Dr. Bronstein is chief resident in Internal Medicine at the Newark City Hospital.

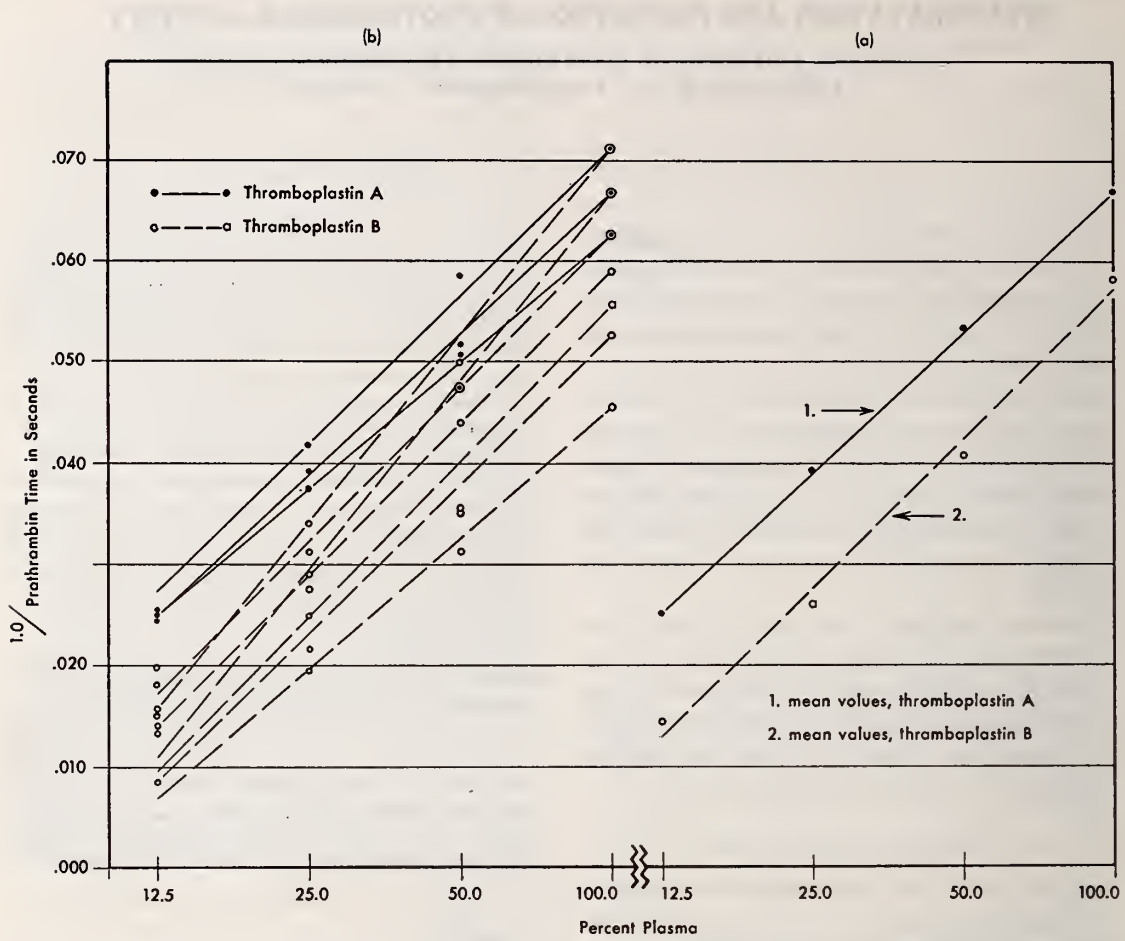


Figure 2—(b) The reciprocal of the prothrombin time in seconds was plotted against the percentage of plasma dilution for the various control levels of both thromboplastin substances. (a) The averages of both thromboplastin substances as seen in (b) are plotted against the percentage of plasma dilution. The uppermost line represents the Thromboplastin A and the lower line, B. It may be noted that the two lines are not parallel and that the Thromboplastin A has a shorter range in seconds than Thromboplastin B.

the time for the first sign of a clot to form was noted. The test on each plasma was repeated twice with each thromboplastic substance. If a clot took longer than 42 seconds to form, whether or not the patient was on anticoagulants, the entire test was repeated from the commencement of the venipuncture.

The average prothrombin time in seconds of the various control dilutions were plotted on graph paper against the percentage plasma used. (See Figure 1.)‡ Another graph was utilized plotting the reciprocal of the prothrombin time in seconds against percentage of plasma. (See Figure 2.) Figure 2 was then transposed so that knowing the seconds of prothrombin time and the control, the percentage of normal prothrombin activity could be read. (See Table I.)

A check on Thromboplastin A[1] was performed utilizing a freshly prepared rabbit brain thromboplastin.

RESULTS AND DISCUSSION

Of the 25 control dilutions studied in this small series it was noted that the more dilute the plasma concentrations, the longer the prothrombin time in seconds, if averages were used. At times, overlapping was noted in individual determinations. This held true for both thromboplastic substances and is best demonstrated in Figure 2. These average figures were then plotted on a graph to determine the dilution curves as seen in Figure 1. It can be seen that in the range of prothrombin time in seconds from 100 per cent to 50 per cent the

TABLE I

Prothrombin Time (in seconds)	Control Prothrombin Time (in seconds) read in %		
	14	15	16
14	100%	..	..
15	86	100%	.
16	72	86	100%
17	60	72	86
18	49	61	75
19	44	50	63
20	40	45	50
21	35	41	46
22	28	35	39
23	27	34	36
24	25	30	34
25	23	27	29
26	21	24	25
27	20	23	24
28	19	22	24
29	18	21	23
30	17	20	21
31	16	19	20
32	16	18	19
33	15	17	18
34	14	16	16
35	13	16	16
36	12.5	15	15
37	less than 12.5%	14	15
38	less than 12.5%	13	14
39	less than 12.5%	13	13
40	less than 12.5%	12.5	13
41	less than 12.5%	less than 12.5%	12.5
42	less than 12.5%	less than 12.5%	less than 12.5%

Table 1—The patient's prothrombin time in seconds is located in the left hand column while the control prothrombin time in seconds (14, 15 or 16) is located at the head of the second set of columns. Following the columns to where they meet, one can determine the percentage of normal prothrombin activity.

curves approximate each other rather closely. However, after this point the curves only correspond in a vague way in that they tend to approach more prolonged prothrombin times with a lowered percentage of prothrombin activity.

In order to get a linear result to aid in more accurate conversion of prothrombin time in seconds to percentage of normal prothrombin activity, Figure 2 was constructed. In this figure, the reciprocal of the prothrombin time in seconds was plotted on semi-logarithmic paper against the percentage of plasma utilized. (Figure 2b). Figure 2a gives the mean values of both thromboplastic substances.

Table I has been constructed to transpose seconds of prothrombin time to percentage of normal prothrombin activity of Thromboplastin A^1 only. The seconds of prothrombin time from 14 to 42 were divided into 1.0. This quotient was located on the graph (Figure 2b) and converted to percentage of normal prothrombin activity. Thromboplastin A^1 was used because there was less variation in control and no marked overlapping of various controls.

It was also found that the freshly prepared rabbit brain preparations when checked against the curves of Thromboplastin A^1 were accurate within plus or minus 2 seconds in all dilutions.

The range of Thromboplastin A^1 controls was less fluctuant (14 to 16 seconds) than the range of Thromboplastin B controls (14 to 19 seconds). No definite correlation between the controls of the two thromboplastic substances could be found.

The correct range for the therapeutic use of anticoagulants varies with individual investigators. One of the many disagreements is whether to control on a percentage or on a second prothrombin time basis.

Rose[7] in using Dicumarol[2] kept the prothrombin activity between 15 and 40 per cent of normal. Wright *et al.*[4] felt that the prothrombin time should be kept within 35 seconds. Pierce and Domenici[8] kept their patients between 45 and 60 per cent, though one of the authors kept his cases between 20 and 40 per cent. McCann[4] feels that by keeping the prothrombin activity between 40 and 50 per cent he had no untoward reactions. Shapiro and Weiner[10] in using Dicumarol[2] have their patients reach elevated prothrombin times every few to several days. According to Bronstein and Witkind[9] the prothrombin time should be kept between two and two-and-one-half times the control, reported in seconds, naming the thromboplastin substance used.

The laboratory error cannot be considered negligible. The averages usually cannot apply to the individual, especially when maintained on anticoagulant therapy.

It is held by some that other substances in the blood are incorporated in the formation of the clot when performing the prothrombin time determination. In the normal plasma control dilutions used in planning the curve, all of these factors are diluted but in actual individual determinations on whole plasma these factors are not. The error possible in transposing prolonged whole plasma prothrombin time to percentage using as a basis diluted control pro-

thrombin time is present. This can of course be overcome by doing determinations on 12.5 per cent plasma as well as whole plasma. In anticoagulant therapy the two-stage method and 12.5 per cent plasma are preferred by some, though as an index of the risk of bleeding the one-stage method with whole plasma seems adequate.

Since some laboratories use the one-stage method and some laboratories report prothrombin time in percentage, feeling it is more readily understood, this paper advocates the use of Figure 2.

CONCLUSION

It would seem more correct to base prothrombin activity and relative prothrombin activity especially with the use of dicoumarin preparations, on seconds of prothrombin time, naming the control, the preparation used, and the dilution of plasma.

The curves used to arrive at percentage of normal prothrombin activity are based on average curves made up of individual determinations which have a wide latitude. In using curves and percentages this should always be kept in mind.

To eliminate the many errors involved, the services of only one or two technicians performing the determinations are required. Each laboratory should work out its own curves and tables and check on these at various times with serial dilutions of normal plasma.

In this series, it was felt that the safe therapeutic range would be 28 to 42 seconds (2 to 2½ times the control) or 12.5 to 24 per cent with Thromboplastin A,[1] the choice of thromboplastic substances. Less error would seem likely with Thromboplastin A[1] because of the ease of preparation compared to other substances.

Each plasma should undergo the prothrombin determination twice with the same thromboplastin substance. With Thromboplastin A[1] as used in this study, the determination was repeated if the prothrombin time was over 42 seconds or less than 12.5 per cent.

SUMMARY

1. The comparative results in the use of two thromboplastic substances in the prothrombin time determinations are discussed. It is felt that the Thromboplastin A[1] is the better preparation.

2. The reporting of prothrombin time in seconds naming the thromboplastic substance used, the control, and percentage plasma employed is advocated. For those laboratories who use percentage of normal prothrombin activity, a graph plotting the reciprocal of the prothrombin time against the percentage of plasma to aid in the conversion of seconds of prothrombin time to percentage of normal prothrombin activity is presented for consideration (Figure 2).

3. The method used in performing a one-stage prothrombin time is presented as well as advantages of the two-stage method and diluted plasma.

4. It is emphasized that each laboratory should assign one technician to prothrombin time determinations, set up its own curves and check these curves at frequent intervals.

I am grateful to the entire attending staff, and to Dr. Murray Shulman, Assistant Director of Pathology, and the hematology technicians of the Newark City Hospital for their cooperation and aid in preparing this communication. Many thanks to Miss Eleanor Bronstein for the typing of this paper.

Dr. William T. Strauss, Medical Director, and Mr. Neil Stasilli of Chilcott Laboratories, The Maltine Company, have been most helpful in the work on prothrombin time determinations. Mr. Stasilli prepared Figures 1 and 2.

116 Fairmount Avenue

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† Geigy Company, New York.

‡ Figure 1. With permission of the authors, Dr. Kern, editor of The American Journal of the Medical Sciences, and the publishers, Lea and Febiger, Philadelphia.

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MANIFESTATIONS OF HYPOGLYCEMIA AND THEIR RELATION TO BLOOD SUGAR LEVELS *

EUGENE REVITCH, M.D., Lyons, N. J.

Untoward reactions due to hyperinsulinism of islet cell carcinoma or to administration of insulin to diabetics have been well known for some time. However, Sakel's introduction of insulin coma therapy for schizophrenia stimulated basic research of the underlying mechanism of hypoglycemic reactions. Observation of patients during treatment with Sakel's method has given us valuable clinical knowledge of hypoglycemia which would have been difficult to gain from random observations of diabetics receiving overdosage of insulin. It is impossible to foretell the amount of insulin necessary for production of various stages of hypoglycemic reactions. Dosage depends neither on weight, nor on sex, race or other known factors. Some patients develop deep coma with small amounts of insulin, others will not respond to several thousand units. For this reason Sakel's treatment begins with a small dose of insulin which is daily increased until the desired reaction is obtained. The early workers started with very small amounts, such as 15 units and increased the dosage cautiously by 5 to 10 units daily. Shurley[1] introduced a massive daily increase of dosage which is now used by most of the insulin units in VA hospitals. The dosage is increased as follows: U 30, U 60, U 100, U 200, U 400 and so on, until the desired depth of coma is obtained. In my own experience, I had to use as much as 2000 units; but larger doses have been reported by other therapists. Regular insulin is injected intramuscularly early in the morning. Intravenous injection has been tried by isolated workers.[2] Insulin injected into the vein will produce hypoglycemic reactions earlier than when the same amount is injected into the muscle. Intramuscular injection is better known and more widely used; the hypoglycemic symptoms are allowed to develop for 4 to 5 hours after which hypoglycemia is terminated with oral or intravenous glucose. The progress of hypoglycemic reactions was described in detail by Himwich *et al.*[3,4] Earlier investigators recorded most of the manifestations of hypoglycemia, but failed to see the sequence of events. Himwich[3] divides the progression of hypoglycemic symptoms into five stages. His tabulation of symptoms was adapted by Shurley and Bond[1] and through them by a great number of insulin units in various mental hospitals.

STAGE I

Sweating and somnolence which may be followed by excitement. In excitement, the patient tosses around and screams but maintains contact with the environment. Psychiatric manifestations of hypoglycemia, such as quarrelsomeness, fugue states and other sudden personality changes, are symptoms of the first stage when they occur either in Sakel's treatment, in diabetics treated with insulin or in patients with islet cell carcinoma.

STAGE II

Myoclonic twitches of extremities, sucking movements, exophthalmos, profuse sweating,

* From the Veterans Administration Hospital, Lyons, N. J.

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dilated pupils, hyperirritability are the most prominent symptoms. The patient's awareness of environment is usually lost. When tested for plantar response, the patient rapidly withdraws the whole leg due to hyperirritability. In some cases, however, the Babinski sign may be positive.

STAGE III

This stage is difficult to recognize. When all the symptoms are present, torsion movements may be elicited. Hyperirritability disappears and the patient does not respond (except with reflex movements) to painful stimuli, such as pressure on the supra-orbital ridge. The Babinski sign is usually positive. The eye signs are important; the patient does not fix his gaze any longer. Nystagmoid jerks, seen earlier, are later replaced by slow to-and-fro pendular movements of the eyes.

STAGE IV

The most characteristic symptom is hyperextension, as in tetanus or in decerebrate rigidity. Pendular movements of the eyes disappear. Pupils have a tendency to constrict, corneal reflex becomes sluggish.

STAGE V

Corneal reflex is absent; pupils constricted; the patient is completely relaxed. Skin is dry. Respiration is depressed, pulse slow. Later in the stage all the tendon reflexes and the plantar response disappear. Although symptoms in general follow the order described by Himwich[4] there are individual variations, and differences in detail. Thus the motor phenomena of stage III are frequently absent. Some patients may lose environmental contact at the end of stage one, and some still have it in stage two. The corneal reflex may be abolished earlier in the progression of symptoms in some patients than in others. Excitement at the end of the first stage may be more or less severe or completely absent. Other patients progress to the deeper stages almost without motor phenomena. Convulsions are not a constant phenomenon in humans as they are in rabbits. Convulsions during treatment are considered as a complication and necessitate termination of hypoglycemia.

The progression of symptoms of hypoglycemia has as its substratum the dissolution of the nervous system, according to the concept of Hughling Jackson. Jackson viewed the nervous system as an integrated unit with the phylogenetically older levels controlled by the phylogenetically newer levels. The destruction of phylogenetically newer (or "higher") levels will liberate the activity of phylogenetically older (or "lower" levels). For instance, the mass reflex in the transection of spinal cord is due to the liberation of the cord from the inhibitory control of higher levels of the central nervous system. What is the reason for Jacksonian dissolution in hypoglycemia? Himwich,[4,5] Gellhorn,[6] and Kraines and Gellhorn[7] show the similarity of symptoms of hypoglycemia and anoxia, and their interaction, by the increase of severity of hypoglycemic reactions, if the experimental animal is placed in an atmosphere with low concentration of oxygen. Oxygen utilization by the brain during hypoglycemia was found to be diminished and the severity of hypoglycemic reactions was found to depend on the degree of diminution of oxygen utilization.[3,4] Why is oxygen utilization diminished during hypoglycemia? Because the brain depends solely on carbohydrates for energy requirement and thus oxygen utilization by the brain is impossible without adequate supply of glucose.[5,6] The greater susceptibility of phylogenetically higher levels to anoxia was demonstrated by Heymans and Bouchaert, as quoted by Himwich.[5] By inhibiting cerebral circulation they found irreversible changes in the hemispheres after 5 minutes, midbrain 15 minutes, medulla 30 minutes. It is also known that the higher levels have greater metabolic requirements, which explains their greater susceptibility to anoxia.

EEG studies during hypoglycemia show a replacement of alpha activity by delta waves which indicates diminished metabolism. Hogland *et al.* (as quoted by Himwich[4]) were also able to demonstrate on a dog that delta waves replace alpha activity earlier in the hemispheres than in the hypothalamus and that alpha activity reappears earlier after termination of hypoglycemia in the hypothalamus than in the hemispheres. Histologic studies of brains of experimental animals sacrificed during or after insulin shock, or of patients who died during insulin coma show that the higher levels of the central nervous system are affected to a greater extent than the lower levels. This is another proof of greater vulnerability of the phylogenetically newer levels. Consequently the stages of hypoglycemic reactions grossly correspond to Jacksonian dissolution of the nervous system. It is a mistake, however, to view the symptoms as due

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entirely to clear cut liberation of certain levels from higher levels, since irritative phenomena, diffuseness of involvement and usually incomplete involvement of various levels take place. The symptoms can be compared only partly with surgical ablation of various levels on experimental animals. For instance, the extensor spasms in the fourth stage are not continuous as in decerebrate rigidity but give way to relaxation because impulses still pass from higher levels. In certain subjects, the difference in vulnerability of various levels is not as great as in others and therefore the lower, more vital centers may be severely involved, when the higher levels are relatively well preserved. The patient is then deeper in coma than he appears to be. Sakel,[8] during his visits to the VA Hospital at Lyons, N. J., attracted our attention to this phenomenon. He says that this is more usual in chronic schizophrenic patients. The same is reported[9] in infants. In infants, the lower phyletic levels may have greater metabolic requirements than the higher levels, which will fully develop only later in life.

Hypoglycemic symptoms are due to anoxia of various levels of the central nervous system. This is not related with anoxia in peripheral blood, as demonstrated by Himwich *et al.*[5] Early investigators[10] have already recorded that there was no direct relationship between blood sugar level[11] and hypoglycemic manifestations.[12]

Hypoglycemic symptoms with normal or high blood sugar have been recorded by various investigators. Judd *et al.*[13] report a 43 year old diabetic woman who developed hypoglycemic coma with blood sugar level of 138. Mintz[14] cites his experience with a diabetic soldier who developed hypoglycemic reactions with blood sugar level of 150 and who felt comfortable when the level was maintained at 200. One of my patients was aroused from a stupor associated with some of the second stage phenomena with one-half glass of a 40 per cent solution of glucose taken orally. He refused to finish drinking the solution. Ten minutes later he became obscene and aggressive. A blood specimen showed 73 milligrams of sugar. After additional intravenous injection of 50 cubic centimeters of 25 per cent glucose, his behavior immediately changed and he became cooperative and friendly as usual. On the other hand John[15] found that out of 23,000 individuals, more than 200 had a fasting blood sugar below 60. Some had a fasting level of 30 without symptoms of hypoglycemia. Himwich[4] quotes Kettringham and Austin who found normal blood sugar level at birth but a drop of hypoglycemic levels within the first few days of life. White (quoted by Himwich[4]) found hypoglycemic levels on 19 older babies, but only one showed hypoglycemic manifestations. When random blood sugar levels are determined on patients during insulin coma therapy one may find extremely low levels while the patient is perfectly conscious and the only symptom may be mild sweating.

Example I:

6:00 a.m.	Insulin 350 U I.M.	
9:00 a.m.	Conscious	Blood sugar 30
9:50 a.m.	4th Stage	Blood sugar 32

Example II:

(a)	6:00 a.m.	U 300 insulin I.M.	
	11:00 a.m.	Sweating, no other symptoms, perfectly conscious.	Blood sugar 30
(b)	6:00 a.m.	U 250 insulin I.M.	
	9:30 a.m.	Perfectly conscious, solves arithmetic problems.	Blood sugar 18
	10:05 a.m.	Thinking somewhat disorganized but still in contact with environment. Sweating.	Blood sugar 9

The behavior of patient Number two with 9 milligrams blood sugar level was the same as in the first case with a blood sugar level of 73. At 18 he showed less mental disorganization than the other patient at the level of 73 milligrams. Patients frequently wake up spontaneously after severe twitches of the second stage or after electric shock is administered during the second stage. Left alone, patients usually lapse back into deeper stages. What is the behavior of blood sugar during these events?

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Example III:

9:25 a.m.	Second stage with severe myoclonic twitches	Blood sugar 11
9:35 a.m.	Spontaneous awakening. Good contact with environment	Blood sugar 25
10:35 a.m.	Severe twitches—Second stage	Blood sugar 11
10:45 a.m.	Spontaneous awakening, pt. talks but contact with environment poor, thinking disorganized	Blood sugar 35

Notice that at the second awakening, contact with environment is not as good as at the first awakening, although the blood sugar is 10 milligrams higher. Georgi,[12] one of the early investigators, pointed out that the lowest hypoglycemic level is reached within 1½ hours after intramuscular injection of insulin and that hypoglycemic symptoms appear later when the blood sugar curve has a tendency to rise. This, I was able to corroborate by using various doses of insulin intravenously and intramuscularly on the same subjects.[2] With the intravenous method, the curve reaches its lowest level within one-half hour; whereas with the intramuscular injection, the lowest level is reached within one to two hours. The onset of hypoglycemic symptoms (such as sweating and stupor) is 45 to 90 minutes earlier with the intravenous than with the intramuscular injection. With widely different amounts of insulin the blood sugar reaches the same level at the same time; but later on, the second part of the curve is more depressed with the greater amounts. Thus for instance:

Example IV:

	Fasting B.S. Mg %	½ Hr. Mg %	1 Hr. Mg %	2 Hrs. Mg %	3 Hrs. Mg %
U 30 I.V.	94	22	30	30	53
U 160 I.V.	89	20	18	26	34
U 30 I.M.	96	39	18	25	35
U 160 I.M.	82	43	18	18	15

Example V:

	Fasting B.S. Mg %	½ Hr. Mg %	1 Hr. Mg %	2 Hrs. Mg %
U 30 I.V.	79	23	33	35
U 390 I.V.	76	26	23	17

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Many authors say that it is not the level of hypoglycemia, but the rapidity of the fall of blood sugar level which determines the depth of reaction.[16] As seen in examples IV and V the rapidity of fall does not elucidate the problem. In example IV, second stage reactions were obtained with 160 units I.V. and I.M., but practically no reactions were obtained with 30 units, although the fall was greater with 30 than with 160 units.

In example V, the descending curve with U 30 (I.V.) was not significantly different from the fall of blood sugar level within the first ½ hour with U 390 (I.V.). Yet, no reactions were obtained with U 30 and loss of consciousness was well established within two hours with U 390 (I.V.). In example IV U 30 (I.M.) and U 160 (I.V.) produced approximately the same level, starting from the first hour after injection; yet U 30 failed to produce the reactions produced by U 160. In certain conditions, however, the rapid drop of blood sugar level may seem to be important. If an insufficient amount of glucose is given intravenously to a patient in insulin coma he will be aroused; but if no additional glucose is given, he will usually slip back within ½ hour into deeper stages of coma than before arousal, although the glucose level reached may be higher than before.

In routine Sakel's treatment, sufficient amounts of insulin never produce reactions within ½ hour, although blood glucose reaches hypoglycemic levels. How can we explain this? Is it due to the fact that administration of glucose produces hyperglycemic levels, which within ½ hour fall down to low hypoglycemic levels, making the fall more precipitous? Or is it due to "functional" impairment of the nervous system which has not recovered enough from hypoglycemia before the injection of glucose in order to function properly with low levels of blood sugar ½ hour after the injection? The second explanation is more plausible since definitely more glucose is needed to arouse a patient from deeper stages of coma than from more superficial stages. The amount of glucose needed for arousal is not related to the amount of insulin used.

Functions depending on phylogenetically lower levels recover before the functions depending on the higher levels. Thus, consciousness is the last to recover. The following observation supports this clinical impression:

6:00 a.m.	Insulin U 175 I.M.	
8:50 a.m.	Early second stage 40 c.c. of 25% glucose administered I.V. Patient was immediately aroused, able to solve arithmetic problems.	Blood sugar 35 Blood sugar 82
9:20 a.m.	Second stage coma	Blood sugar 35
9:50 a.m.	Deep 4th stage	
10:15 a.m.	Deep 4th stage 40 c.c. of 25% glucose given I.V., respiration improves immediately, pupils dilate. Consciousness not regained. 220 c.c. of 25% glucose I.V. added, patient thrashes around, sensorium not clear. 50 c.c. of 50% glucose added. Blood sugar 298 mg %—Patient aroused, sensorium as clear as at 8:50 a.m. with B.S. 82 Mg %.	Blood sugar 33 Blood sugar 75

Since glucose level in venous blood alone is insufficient to explain hypoglycemic manifestations, several investigators incriminated other compounds. Freudenberg[17] suggested that other reducible substances (such as glutathione) and *not* glucose determine the depth of reactions. Harris *et al.*[18] in their biochemical studies during hypoglycemia found that the level of serum potassium dropped over 20 per cent during hypoglycemia and patients with the lowest drop reacted more severely. The potassium, not unlike glucose, reaches the lowest level within two hours after injection of insulin and then rises. Billig and Hesser[19] found an increase of histamine during hypoglycemia, the level rising with depth of coma. The changes of histamine level corresponded to spontaneous fluctuations of hypoglycemic symptoms. Direct action of insulin on the central nervous system was also incriminated.[2] In the light of physiologic research on relationship of hypoglycemia to anoxia, the fluctuation of the level of various compounds in the blood is an epiphenomenon rather than the cause of hypoglycemic manifestations.

SUMMARY

Hypoglycemic manifestations can be divided into five stages. The physiologic basis for this is the "dissolution" of the central nervous system, according to the concept of Hughling Jackson. Hypoglycemia depresses various levels of the nervous system through anoxia, since carbohydrates are the only source of energy utilized by the brain. The higher levels of the nervous system are depressed earlier because their metabolic requirements are greater. *No direct relationship between blood sugar level and hypoglycemic manifestations could be found.* Subjects who showed manifestations of hypoglycemia with normal or hyperglycemic levels, and subjects without any signs of hypoglycemia with extremely low blood sugar levels, are known.

The same subject during insulin coma therapy may or may not present various stages of hypoglycemic manifestations with the same blood sugar levels. The rapidity of fall of the blood sugar level is found to be an insufficient explanation of hypoglycemic manifestations. Fluctuations of other compounds of blood, such as potassium and histamine are thought to be not the cause of the clinical manifestations of hypoglycemia but epiphenomena. The explanation of hypoglycemic reactions resides in the functional impairment of various levels of the central nervous system due to focal anoxia. Clinical experience shows that depending on the functional state of the central nervous system, various levels of blood sugar will be necessary for proper oxygen utilization by the brain.

Blood sugar determinations of examples IV and V were done at the Philadelphia Psychiatric Hospital, Philadelphia, Pennsylvania. Folin-Wu method was used.

The other blood sugar levels reported in this paper were determined at the laboratory of the Veterans Administration Hospital, Lyons, New Jersey, Technician H. Tannenbaum. Folin-Wu Method with Rouy photometer was used.

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Veterans Hospital

STATE ACTIVITIES

TRUSTEES' MEETINGS

JULY 13, 1952

A regular meeting of the Board of Trustees was held on Sunday, July 13, 1952, at Seagirt, N. J. The following is a summary of the principal actions taken by the Board at this meeting:

Approval was given to a motion that the Society present an exhibit at the New Jersey State Fair, under the jurisdiction of the Subcommittee on Public Relations.

With reference to the announcement that the A.M.A. House of Delegates has accepted the Medical Society's invitation to hold its 55th Annual Session in Atlantic City, the Board directed that the A.M.A. be informed that The Medical Society of New Jersey will be happy to serve again as host to the American Medical Association.

A motion that the chairman of the Advisory Committee on Cancer Control of The Medical Society of New Jersey act as liaison to the New Jersey Division of the American Cancer Society, in an advisory capacity, was adopted.

Approval was given to the action of President Murray in having sent a telegram to the American Cancer Society, New Jersey Division, regarding their change of by-laws.

A motion that a committee be appointed by the chairman to voice the strong objection of The Medical Society of New Jersey to the new policy recently taken by the American Cancer Society, New Jersey Division, without consulting with the Medical Society was adopted. The chairman named Dr. Murray, Dr. Decker, and Dr. Lance as members of this committee.

Regarding a resolution dealing with Veterans Administration affairs given by the House of Delegates to the New Jersey delegates to the A.M.A. for presentation at the June meeting of the A.M.A., Dr. Costello reported that the resolution had not been presented because it was later discovered that it was based on premises which could not be substantiated. The Board then adopted a motion endorsing the action of the A.M.A. delegates in withholding the resolution.

Approval was given to a motion that Dr. Henry A. Davidson, retiring editor of THE JOURNAL of The Medical Society of New Jersey, be retained as editorial consultant for a period of one year.

The Board adopted a motion that a committee be appointed by the chairman empowered to select an editor as soon as possible. The chairman designated Dr. Harrold A. Murray, Dr. Vincent P. Butler, and Dr. J. Lawrence Evans, Jr., as members of the committee.

In connection with referrals from the House of Delegates—

1. The Board deferred action on the recommendation regarding the scientific program of the annual meeting until after the next regular meeting of the Annual Meeting Committee.

2. The Board referred the recommendations made by the Advisory Committee on Conservation of Vision and Hearing regarding legislation to the Subcommittee on Legislation for study and report.

3. The Board referred the recommendations made by the Advisory Committee on Pharmaceutical Problems regarding the State Uniform Narcotics Law and the dispensing of drugs to the Subcommittee on Legislation for study and report.

4. The Board referred the recommendation of Reference Committee C, dealing with the resolution concerning Medical-Surgical Plan, as received from the Mercer County Medical Society, to the Judicial Council for its decision regarding the ethical aspects of the suggested procedures. The Board requested the Judicial Council to submit a report of its decision.

The renewal of the Veterans Administration contract for 1952 and 1953 was approved.

The nomination of Dr. Patrick J. Corrigan of Mercer County as a member of the Board of Trustees, Medical-Surgical Plan, to serve until the next annual meeting of the Corporation and until his successor is elected and qualifies, was approved.

A resolution from the New Jersey Pharmaceutical Association concerning the dispensing of drugs by physicians was referred to the Medical Practice Committee for study and recommendations.

A resolution from the New Jersey Pharmaceutical Association concerning the problem of duplication and substitution of drug products, and the distribution of parenterals and drug products to the consuming public as this problem relates to public health and welfare, was referred to the Joint Committee on Professional Relations for study and recommendation.

A resolution from the New Jersey Pharmaceutical Association concerning imprinted prescription blanks, was referred to the Medical Practice Committee for study and recommendation.

The chairman reported appointment of the following as members of the Health Survey Committee: Dr. Sigurd W. Johnsen, Chairman; Dr. C. Byron Blaisdell, Dr. Daniel Bergsma, and Dr. Harrold A. Murray, with Dr. Reuben L. Sharp and Mr. Richard I. Nevin as *ex-officio* members.

Approval was given to a motion that the chairman of the Section on Urology be authorized to appoint a secretary to the Section on Urology, to serve until the next annual meeting.

The Board approved the following recommendations made by the Subcommittee on Public Relations:

1. That the slogan "Public Relations For Medicine Means Personal Responsibility For You!" be adopted for the year and brought to the attention of the membership through the columns of the *Membership News Letter*.
2. That a committee of three be named to formulate the wording of a plaque to be submitted for final approval subsequently, and to be distributed to the members of the Society for display in their offices or waiting rooms.
3. That a committee of three be appointed to assist Mr. Nevin in the preparation and publication of the "Junior Health Hints".

Concerning the question as to whether or not the Medical Directory should list certifications by specialty boards for physicians, the Board expressed the opinion that this information should be included.

OCTOBER 5, 1952

A regular meeting of the Board of Trustees was held on Sunday, October 5, 1952, at the Executive Offices in Trenton. The following is a summary of the principal actions taken by the Board at this meeting:

The Board approved the recommendation of the special committee for the selection of a new editor for THE JOURNAL that Dr. Rowland D. Goodman, 2d, Essex County, the present nonsalaried associate editor, be appointed as acting editor for a period of six months, beginning November 1, 1952.

In response to communications requesting policy guidance regarding the status of osteopaths and chiropractors in Medical Civil Defense, it was the censensus of the Board that those making such inquiries should be informed that anyone who can aid in times of Civil Defense should be utilized; that the Medical Society has nothing to do with organizing the Civil Defense setup as such, but that it is willing to cooperate with all groups under the terms outlined by the Civil Defense authorities.

The Board authorized payment of dues by which The Medical Society of New Jersey will become a participating member in the Council For Local Public Health Services For New Jersey.

A communication from the General Directory Manager of the New Jersey Bell Telephone Co., outlining the reasons for permitting doctors to show—in connection with their classified telephone directory listings—the office hours, and, in the case of specialists, the branch of medicine to which they restrict their practice, was referred to the Medical Practice Committee for study, with the request that the committee indicate specifically in its report its recommendations as to what should be published.

The Board approved a request from the Governor, submitted through Dr. Samuel Blaugrund, the Society's liaison with the State Health Department, that The Medical Society of New Jersey approve a conference for the prevention of chronic illness which the Governor plans to call for some time in December, 1952. Dr. Blaugrund was instructed to so notify the Governor.

A motion was adopted designating the President and Chairman of the Board of Trustees as the Society's representatives on the Permanent Committee on Medical-Surgical Plan.

The report of the Audit Committee—Dr. Greifinger, Chairman; Dr. Wilentz and Dr. Kump—approving the audit for the fiscal year ending May 31, 1952, as correct, was accepted and approved by the Board.

The Special Committee on the Health Survey, through its chairman, Dr. Sigurd W. Johnsen, presented its report of the results of the completed public opinion research poll. The following recommendations of the committee were approved by the Board:

1. That a suitable news release covering the survey highlights be prepared by the Executive Officer, in conjunction with the President and special committee members, and released at the proper time.
2. That The Medical Society of New Jersey adhere to its insistence upon maintenance of standards for all branches of the healing arts, and that the requirements for admission to practice chiropractic be made to conform to these standards.
3. That a copy of the news release of survey highlights be sent to the chairmen of the following committees: Welfare, Subcommittees on Legislation, Medical Practice, Public Health, and Public Relations; the Medical-Dental, Medical-Legal, and Medical-Hospital Liaison Committees; and that a copy of the release also be sent to the Woman's Auxiliary and secretaries of all county medical societies.
4. That the committee be discharged as having completed its work, and that a coordinating liaison

committee be named, if necessary, to carry out the recommendations of the Board of Trustees. The Board then unanimously adopted a motion thanking Dr. Johnsen and the members of his committee for the excellent work they had done in conjunction with the survey.

It was reported that the Governor was about to appoint a special board to study the licensing of chiropractors, and it was asked if it was acceptable for a Trustee to accept appointment to such a board. A motion was unanimously adopted instructing any member of the Board of Trustees to accept such an invitation.

A communication was read from the chairman of the Annual Meeting Committee, Dr. Jerome G. Kaufman, outlining the preliminary plans and arrangements for the 1953 convention.

1. The Board approved a recommendation that the 1953 annual meeting be limited to the eleven section meetings as voted by the section officers in 1952.

2. The Board approved the proposed schedule of events with this modification, that the discussion period on Medical-Surgical Plan at the first session of the House of Delegates be scheduled to follow the business meeting of the House instead of to precede it.

3. The Board also approved a motion that the Trustees appoint a committee to study the whole question of scientific sections and to submit to the 1953 House of Delegates its recommendations on sections and section meetings, to be followed in 1954 and thereafter.

In connection with its approval of the report of the Welfare Committee concerning its meeting of September 14, the Board approved the following recommendations:

A. From the Subcommittee on Legislation (meeting of June 28, approved in principle by the Board of Trustees at its meeting at Seagirt on July 13, 1952):

1. With reference to the question of licensing chiropractors, it was recommended that an examination in basic sciences, prepared by an impartial group of educators in conformity with the standards set by the State Board of Medical Examiners, be established as a prerequisite for all candidates for licensure, which examination is to be followed by another examination in the specialized form of the healing art under which the candidate seeks to be admitted to practice.

2. That a plan of organization and action be followed this year, the objective of which is to make contact with and attempt to influence legislators from the county level rather than from the state level as heretofore.

3. That a dinner meeting be held in the Fall at which the members of the subcommittee would meet with the county keymen and others to discuss the program and procedure for the coming legislative year.

B. From the Subcommittee on Legislation (meeting of September 10, 1952):

1. In response to recommendations emanating from the American Medical Association Headquarters urging support of the Keogh-Reed Bills (HR-8390—HR-8391), that a program of support for this legislation be sponsored, it proposed that not only the members of The Medical Society of New Jersey should be urged to contact legislators, but also members of other professions and organizations and the general public.

2. That the House Committee be reminded that space for an adequate office for the Executive Secretary and the files of the subcommittee is to be made available as a necessary means for carrying out the revised program of activities for the coming year.

3. That a letter, drafted by the Executive Officer, be sent to Mr. Theodore A. Merkt, State Legislative Chairman of the Citizens Chiropractic League of New Jersey, in response to a letter addressed to Dr. Harrold A. Murray reporting a new chiropractic bill in preparation and soliciting a conference with representatives of the Medical Society. The committee directed that the letter of reply contain a request for a copy of the proposed legislation in its present form, and express the willingness of the subcommittee—after proper study of the proposed bill—to confer with representatives of the chiropractors.

4. That the office of its Executive Secretary should assemble a kit of informative materials concerning the background and present status of chiropractic in New Jersey to be supplied to the county keymen at the dinner meeting to be held in the Fall.

5. That in those counties of the state where senators are up for election this year, keymen and county representatives should be encouraged and assisted by the Executive Secretary to support acceptable candidates for the offices involved.

6. That all advisory committees maintain close liaison with the Subcommittee on Legislation and afford it timely apprisal of all legislative matters that it considers significant.

7. That the Executive Secretary acquaint Assemblyman Tompkins with the recommendations of the Advisory Committee on Pharmaceutical Problems and ask his early cooperation in correcting the legislation involved.

8. That its Executive Secretary contact Mr. Gerald O'Mara, legal counsel to the Society, and ask him to confer with Dr. Harrison S. Martland, Chief Medical Examiner of Essex County, to study and consider for possible revision the laws governing the office and function of coroners throughout the State.

C. From the Subcommittee on Medical Practice (meeting of September 7, 1952):

1. That the Medical Society request the various county medical societies to form sections on anesthesiology for the express purpose of starting Anesthesia Study Commissions.

2. With reference to a resolution adopted by the New Jersey Pharmaceutical Association regarding

the use of imprinted prescription blanks and referred by the Board of Trustees to the subcommittee, that it be considered unethical for any physician to use a prescription blank furnished by a pharmacist and imprinted with the pharmacist's name and address.

A request was read from the Essex County Medical Society inquiring as to what action the State Society should take in the matter of reducing or waiving the State Society assessment for full-time staff members of the new Veterans Administration Hospital in East Orange. The Board adopted a motion declaring that the State Society will not reduce or waive the State Society assessment for Veterans Administration staff members, on the grounds that they suffer no hardship in their employment.

INDUSTRIAL HEALTH FELLOWSHIPS

The Institute of Industrial Health of the University of Cincinnati announces a limited number of fellowships for physicians interested in the field of industrial medicine. Requirements include an M.D. degree from a Class A medical school and two years' approved hospital training. The fellowship consists of a two-year didactic course and one year of practical experience. Stipends for the fellowship range from $2,100 to $3,000 for the first two years. The compensation for the third year will be made by the industry in which the candidate is being trained. Requests for further information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

INDUSTRIAL HEALTH CONGRESS

The American Medical Association's Council on Industrial Health will hold its annual Congress in Chicago on January 21 and 22, 1953. Reports will be heard from workers, industrial leaders and medical men concerning industrial health centers, human relationships, and aspects of occupational cancer.

LABORATORY COURSES IN TUBERCULOSIS

The Division of Chronic Disease and Tuberculosis, Public Health Service, offers two sets of courses in the laboratory diagnosis of tuberculosis for physicians and laboratory technicians. The courses for physicians, March 30 to April 3, 1953 and November 9 to 13, 1953, are open to laboratory directors, senior laboratory staff members, physicians and others of comparable professional standing.

The courses for laboratory personnel are dated March 16 to 27, 1953 and November 16 to 27, 1953. These courses will cover training in all phases of tuberculosis bacteriology, including determination of drug sensitivity. No tuition will be charged, but reservations for these courses should be made well in advance. They will be given at the Bacteriology Laboratories of the Communicable Disease Center, Chamblee, Georgia.

For further information address inquiries to the Laboratory Training Services, Communicable Disease Center, Public Health Service, P O Box 185, Chamblee, Georgia.

OBITUARIES

DR. ROYDEN W. DAVISON

Dr. Royden W. Davison, formerly of Trenton, died on September 9, 1952 at Spofford, N. H., after a long illness.

Dr. Davidson was born at Hinsdale, N. H., in 1880. He received his medical education at the University of Pennsylvania Medical School, graduating in 1907. He interned at St. Francis Hospital in Trenton and continued his connection with the hospital until his retirement four years ago.

Dr. Davison was an emeritus member of the Mercer County Medical Society and The Medical Society of New Jersey.

DR. DANIEL B. STREET

Dr. Daniel B. Street died at the Jersey City Medical Center on October 21, 1952 at the age of 77.

Dr. Street was born in Washington, D. C., was graduated from George Washington University in 1897, and had practiced in Jersey City since 1903. In the course of his long medical career he served as a physician for the Jersey City Board of Education, as a contract surgeon to the Army in the Spanish-American War, and as a member of the Medical Center Hospital staff since 1913. He was a past-president of the Hudson County Medical Society, past-president of the Physicians and Surgeons Club of Jersey City, and a member of the Practitioners Club of the same city.

Medical-Surgical Plan of New Jersey

"New Jersey's Blue Shield Plan"

QUESTIONS AND ANSWERS
ON
MEDICAL-SURGICAL PLAN OF NEW JERSEY

Question I.

What information should be obtained from a patient who presents a Medical-Surgical Plan "identification card"?

Answer:

The only information required to process a claim for M.S.P. benefits is that which is specified in Part I of MS53—the (blue) Service Report. This includes the full name and address of the patient, the patient's date of birth (frequently more than one member of the family shares the same given names), the subscriber's full name, name of the employer, M.S.P. Contract number, and relationship of patient to subscriber.

It is important to ask the patient or subscriber to check the question whether the annual income is or is not more than $5000, so that the Participating Physician may know whether he should accept Plan payment as payment in full for the services covered by the Subscription Contract.

Spaces No. 11 and No. 12 also inquire whether the case in eligible for Workmen's Compensation benefits or is a VA case.

Question II.

What services are eligible for Plan payment (covered by the terms of the Subscription Contract)?

Answer:

(a) In a *surgical case,* the operative procedure and all pre- or postoperative care rendered incident thereto by one or more physicians in the hospital are included in Plan payment for the operative procedure.

(b) In a *medical (not surgical) case,* the services of the attending physician, rendered in the hospital, which are paid for on a per diem basis, comprising $10 for the first day and $5 for each day thereafter, up to a total of 21 days in any Contract year in which medical care is actually given, are included in the Plan payment. (See Schedule for additional payment available in medical cases requiring "unusually repeated or prolonged attendance".)

(c) In a *maternity case,* Plan payment for the obstetrical delivery also includes pre- and postnatal care, wherever rendered. Delivery service in a case of premature birth (prior to seventh month) must be rendered in hospital to be eligible for Plan payment.

(d) In an *emergency surgical case* (caused by accident) the Plan payment, according to Schedule, but with a maximum of $25, includes only those services rendered within 48 hours after the accident.

(e) *Anesthesia services, and transfusion services.* Transfusion is not payable as a separate service when rendered by the anesthetist concurrently with anesthesia, or when rendered by the same physician who renders the medical, surgical or obstetrical services in the particular case.

(f) *Consultations,* on request of the attending physician, but only when duly recorded as a formal consultation (see Schedule for payments and limitations).

(g) *Services for removal of tonsils and adenoids,* in hospital or elsewhere.

(h) *Surgical services of an emergency nature in out-patient development,* without admission of patient as a bed patient in hospital.

Question III.

What services are excluded as ineligible for Plan payment, under the terms of the Subscription Contract?

Answer:

(a) Services rendered, or when hospital admission occurred, prior to the date of actual enrollment of the patient under the Subscription Contract.

(b) Medical services in hospital beyond the 21 day limit of medical care provided in the Contract.

(c) Medical (not surgical) services rendered outside of hospital.

(d) Surgical services, except of an emergency nature, when rendered in out-patient department, without admission of patient as a bed patient.

(e) Surgical services in physician's office, except for (1) emergency surgery following an accident and within 48 hours of the accident; (2) T. and A.

(f) Services for, or in connection with rest cures; services for solely diagnostic purposes.

(g) Services for conditions occurring during military service or wholly or in part compensable under state or federal Workmen's Compensation laws or similar legislation; services rendered during hospitalization provided under the laws of the U.S.A. or of any state or political subdivision of a state.

(h) Services of a surgical assistant or hospital resident physician or intern; services of a dentist or of any physician practicing under a limited license.

(i) Blood or blood plasma; radium treatments; electrocardiograms; hydrotherapy; X-ray therapy; physiotherapy; drugs, anesthetics, medical or surgical appliances, medications or dressings, X-ray and laboratory examinations, hospital service or services covered by a hospital service plan contract.

(j) Services rendered outside an approved hospital except as specified in Question II above.

Question IV.

What is the policy of the Plan relative to payment of medical (non-surgical services) required in the course of hospitalization of a surgical patient?

Answer:

Plan payment for a surgical procedure, in surgical cases without complicating medical disease, includes the procedure and the pre- and postoperative care rendered incident thereto by the surgeon or other physician during the particular hospital admission.

Payment for medical care, in addition to the surgical benefit, is eligible only when there is a complicating medical condition requiring definitive medical attendance, other than the routine pre- and postoperative care, by a physician other than the operating surgeon. Such payment is made to the medical attendant on a per visit basis (see Question I-b).

COMMUNICATION FOR THE APHASIC

When a physician falls ill, too often he is beset by despair, fear, and doubts for his return to a full and active professional life. However, when Dr. Hamilton Cameron* was stricken with a cerebro-vascular accident accompanied by hemiplegia and aphasia, he was most overwhelmingly depressed by his inability to communicate with the outside world after consciousness returned. As he states it, "I could not speak and I wanted many things but could not make myself understood. I was a shut-in within a paralyzed body and, a shut-out from the world outside". He thereupon applied himself to remedying this situation, and developed a new hand sign-language. He first utilized his healthy left hand and fingers, which was construed by his attendants as the development of a psychosis. Before long it was recognized that he was trying to express himself, and thus a "Hand Talking Chart" was the result. This chart is easy to master for a young child, adult attendant, physician or nurse. The attendant learns the chart, and teaches it to the aphasic patient. With a small amount of practice linguistic rapport is rapidly developed, and the patient uses it until he regains the use of his own speech.

*Goldstein, H., and Cameron, H.: New Method of Communication for the Aphasic. Arizona Medicine (August 1952).

CANCER CYTOLOGY BIBLIOGRAPHY

The Public Health Service of the Federal Security Agency has published a complete bibliography of the cytologic diagnosis of cancer dated February 19, 1952. All pertinent material is listed by article title, author index, and subject index. Further information may be obtained from the National Cancer Institute of the National Institutes of Health, Bethesda, Maryland.

ORAL PATHOLOGY MEETING

The New York Institute of Clinical Oral Pathology announces a meeting which will be open to the dental, medical and allied professions in celebration of its twentieth anniversary to be held in Hosack Hall, The New York Academy of Medicine, 2 East 103 Street, New York City, on Monday evening, January 12, 1953, at 8:30.

Dr. Charles S. Cameron, Medical and Scientific Director and Vice-President of the American Cancer Society, Inc., will speak on "Cancer: Retrospect and Prospect".

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, October 10, 1952, DR. ROBISON D. HARLEY, presiding.

The Society was honored at this meeting in having for its guests the members of the Atlantic County Dental Society. They were formally and warmly welcomed by the president. The Society was further honored by the presence of two guests from the State Society, DR. VINCENT P. BUTLER and MR. RICHARD I. NEVIN. Dr. Butler, Second Vice-President of the State Society, spoke on a subject of mutual interest to the medical and dental professions: the establishment of a medical-dental school in New Jersey. He concluded with a plea that each member conduct his own campaign in soliciting public support and projecting these ideas for public view. Mr. Nevin extended greetings from the officers of the State Society and spoke briefly of public relations objectives.

The guest speaker was MR. LEO T. CLARK, Special Agent of the Federal Bureau of Investigation. Mr. Clark, in an informative and entertaining talk, traced the origins of the F.B.I. from its small beginnings to the present nation-wide intricate set-up that safeguards the country.

Due to the lateness of the hour, it was decided to dispense with the usual business meeting, and to defer all business until the November meeting.

The evening concluded with an enjoyable buffet supper at which the Society was host to the members of the Dental Society.

BERGEN COUNTY

John E. McWhorter, M.D., Reporter

The regular monthly meeting of the *Bergen County Medical Society* was held on November 12, 1952, at the Hackensack Woman's Club, Hackensack.

The following applicants were elected to membership: DRS. DONN E. BONANNO, PATRICIA DODD, WILLIAM L. DORRANCE, HARRY FLEISCHER, ROBERT S. MCDUFFIE, CALVIN W. TRIBIANO, JOHN L. COUPER and FRANK M. DAIN. The following were advanced from Associate to Regular membership: DRS. JANE A. ERGANIAN, DAVID J. FANT and WILLIAM H. FLOYD, JR. DR. GEORGE C. HENNIG was elected to Courtesy membership.

Dr. Barlow welcomed representatives of various organizations to the meeting and announced that the program had been prepared jointly by the Society and the Woman's Auxiliary to the Medical Society. The President of the Auxiliary, MRS. STEWART ALEXANDER, shared the platform with Dr. Barlow as the following program was presented:

"Why New Jersey Needs a Medical-Dental School"—STUART Z. HAWKES, M.D., Vice-Chairman, Special Committee on Medical School, The Medical Society of New Jersey.

"Both Medical Needs and Dental Needs Must Be Served"—DR. WALTER A. WILSON, Secretary, State Board of Registration and Examination in Dentistry.

"New Jersey Can Afford It"—JUDGE PHILIP R. GEBHARDT, Former President of the New Jersey Bar Association.

BURLINGTON COUNTY

William F. Betsch, M.D., Reporter

A regular monthly meeting of the *Burlington County Medical Society* was held on the evening of October 9, 1952, at the Riverton Country Club with PRESIDENT ARTHUR B. PEACOCK, M.D., presiding.

TIMOTHY H. TALBOT, JR., M.D., Associate in Medicine and member of the Section of Hematology, Hospital of the University of Pennsylvania, speaking on "Current Problems in Blood Transfusion", reviewed some of the potential hazards of transfusion and the shortcomings of stored blood.

A short business meeting followed during which DR. DAVID S. BRASHEAR and DR. WILLIAM R. WATSON, JR. of Beverly, were elected to membership.

CAMDEN COUNTY

James P. Harbeson, III, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held at the Dispensary Building on November 4, 1952, with President Collier presiding.

Having been elected to full membership, DRS. EDWARD MITCHELL, FLORENCE C. SLATER, HUGH D. PALMER, WILLIAM F. FEARN and OTTO BROWN were introduced to the Society.

The scientific program of the evening consisted of four interesting cases. These were:

1. Post Irradiation Perineal Reconstruction, presented by DR. ARTHUR W. VONDEILEN.
2. Hemothorax, Massive, Due to Rupture of an Aneurysm of the Thoracic Aorta, presented by DR. HAROLD K. EYNON.
3. Ilial Hernia, presented by DRS. IRVIN E. DEIBERT and ROBERT A. COOPER.
4. An Unusual Abdominal Accident—Buzz Saw Laceration, presented by DR. ELMER L. GRIMES.

DRS. ALEXANDER INTROCASO, CHARLES F. GRABIAK, BENJAMIN R. PARADEE, ERNEST F. DOHERTY and JOHN H. CAPUTI were elected to membership.

Dr. Cooper spoke briefly to the Society urging the members to support the Community Chest Drive.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

The Woodbury Country Club was the scene of the Annual Ladies Night and Social Session of the *Gloucester County Medical Society* on the evening of October 16, 1952. DON B. WEEMS, M.D., President of the Society served as toastmaster for the occasion.

Among the invited guests of the Society were U. S. Senator ROBERT HENDRICKSON, State Senator HAROLD HANNOLD, Assemblyman MILTON SILVER, and press representatives.

HENRY B. DECKER, M.D., President-Elect of The Medical Society of New Jersey, brought us greetings. Mr. RICHARD I. NEVIN, Executive Officer of the State Society, also favored us with a few well-chosen words.

After a delicious dinner, we were honored to have as our speaker of the evening the senior U. S. Senator from New Jersey, the Honorable H. ALEXANDER SMITH. Senator Smith, the son of a doctor, earnestly and interestingly discussed "America's Foreign Policy". More than one hundred persons listened as he described our many mistakes in the past and the hope for better things in the future.

HUDSON COUNTY

John L. Varriano, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on November 11, 1952, at Murdoch Hall, Medical Center. DR. DONNELLY, president-elect, occupied the chair in the absence of Dr. Periberg.

Dr. Donnelly read a communication dated November 7, 1952, from Dr. Daniel F. Featherston, Chairman of the Judicial Council of The Medical Society of New Jersey, which dealt in a broad manner with the importance of maintaining the exalted character of the doctor-patient relationship.

There was a general discussion concerning the organization and duties of the Physician Resources Committee, the Advisory Committee to Selective Service in Hudson County. A motion "that it be considered the sense of this Society that members of Priorities I, II, III, and IV should not be considered medically essential" was made, seconded, and carried.

Elected to membership were DRS. THOMAS J. CONNOLLY, JR., REGINALD H. FARRAR, JR., and MARIE MADISON METOYER of Jersey City; and ISRAEL SIEGEL of Bayonne.

The scientific session was arranged through the courtesy of the Hudson County Heart Association by Dr. Nathan Frank and Dr. Emil H. Grieco, president and program chairman respectively of the Association. Guest speaker was DR. ABRAHAM JEZER, Assistant Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University; Associate Physician at Montefiore Hospital; and Cardiologist at Altro Workshops and Seton Hospital. His subject was "Can the Cardiac Work?" Carefully analyzing and evaluating the findings of a four-year period of personal observation at the Altro Workshops in New York City, Dr. Jezer concluded with the statement that "there are comparatively few cardiacs who cannot work".

MIDDLESEX COUNTY

George M. Benko, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on October 15, 1952, at Roosevelt Hospital, Metuchen. Due to the unavoidable absence of DR. CHARLES H. CALVIN, the president, DR. CARLYLE MORRIS, Vice-President, presided.

DRS. ROBERT FREEMAN and HUGH WILLIAMS of Highland Park, were elected to Regular membership from Associate.

Dr. John H. Rowland reported for the Chronic Disease Hospital Committee, which studied the County's facilities and needs for the care of the chronically ill. This committee recommended that the County build a two-hundred bed chronic disease hospital of one story construction for safety and economy. The committee also recommended that a full report of the Committee's findings be sent to the Board of Freeholders and the press. These recommendations were seconded and carried.

Dr. Edward Brezinski, reporting for the Public Health Committee, stated that a "Better Breakfast Week" program is being promoted by this committee to bring to the public's attention the important role of the 'morning meal' in an adequate diet. Dr. Brezinski also stated that a "Public Health Night" will be held on November 13 at the Perth Amboy High School Auditorium, at which time various prophylactic inoculations will be made available to the public.

Dr. William C. Wilentz reported that the response has been very satisfactory to the request for physicians willing to make the necessary examinations in Disability Compensation Cases. He stated that 31 such requests have been fulfilled thus far.

Dr. Stanley A. Gadek reporting for the Physicians Placement Bureau stated that two or three requests had been acted upon recently. In each instance the area in question had been found to be adequately supplied with physicians.

Dr. Raymond J. Gadek, the secretary, then read a letter from the Secretary of The Medical Society of New Jersey regarding fluoridation of public water supplies for better dental health. On recommendation of Dr. Morris, this letter was referred to the Public Health Committee for further consideration.

Dr. Morris then introduced DR. RICHARD B. CATTELL, Surgeon at the New England Baptist Hospital and the Lahey Clinic and Surgeon-in-Chief of the New England Deaconess Hospital, the guest speaker of the evening, whose subject was "Management of Premalignant and Malignant Lesions of the Large Intestine". Dr. Cattell gave a brilliant lecture which was generously supplied with illuminating statistical analyses gleaned from his wide personal experience in this field. The lecture was illustrated with lantern slides and on completion of the lecture, he presented an excellent color movie of his surgical technics.

MONMOUTH COUNTY

Sidney M. Hodas, M.D., Reporter

The staff of the Army Hospital at Fort Monmouth were hosts to a dinner meeting of the *Monmouth County Medical Society*, held October 22,

1952. The Society was welcomed by Brigadier General Edwin R. Petzing, Commanding General of the Signal Corps Engineering Laboratories, and by Colonel J. W. Raulston, Post Surgeon.

The feature of the evening was a presentation concerning "Repair of Extra-Cellular Fluid in Diabetic Acidosis" by Dr. J. J. Smith, Medical Director and Physician-In-Chief, Jersey City Medical Center and Assistant Professor of Clinical Medicine, Cornell Medical College.

Drs. Abram S. Collis and Morton F. Trippe were elected to unexpired terms on the Executive Committee, Dr. Collis for two years and Dr. Trippe for one year. Dr. Harry M. Poppick of Keyport, was elected to membership as a transfer from the Colorado State Society. Dr. Herbert A. Knapp of Asbury Park was elected to Associate membership.

PASSAIC COUNTY

David B. Levine, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Medical Society Building on October 21, 1952, with Dr. Joseph M. Keating, the President, presiding.

The following were elected to serve as Building Trustees until May 31, 1955: Leon E. DeYoe, Samuel Ginsburg, Wayne W. Hall and Dean A. Wry.

The resolution on fluoridation, adopted by the House of Delegates in May, was read by Dr. Keating and adopted.

Dr. Thomas F. X. Lenihan of Fairlawn, was elected to Active Membership; and Drs. Paul F. Crutchlow and Boris Schwartz of Paterson, were elected to Associate Membership.

Dr. Arthur C. DeGraff, Chief of New York University Cardiac Clinic and Professor of Therapeutics, New York University, spoke on "Therapy in Coronary Insufficiency", with lantern slide illustrations.

Following the scientific program a letter was read from Dr. Joseph F. Londrigan, Executive Secretary of the State Society's Subcommittee on Legislation, informing our Society of the record of last year's voting in the Legislature.

UNION COUNTY

Leslie M. Townsend, M.D., Reporter

Narcotic control problems featured the regular meeting of the *Union County Medical Society* held November 12, 1952, at the Johnson & Johnson Auditorium in Cranford. Many members of the Union County Pharmaceutical Association attended by invitation and took part in the discussion that followed the speeches. Mr. Daniel Belmont, Narcotic Agent of the Treasury Department, spoke on "The Physician in Relation to Narcotics", and Detective Philip Wittcoff of the New Jersey State Police spoke on "The New Jersey Uniform Narcotic Act". Both speakers emphasized that the details and minutiae of the Treasury Department regulations were actually designed to help and protect the physician in the *proper* prescribing and use of narcotic drugs.

Preceding the above narcotic symposium the Society had the pleasure of hearing Dr. Vincent P. Butler, Second Vice-President of The Medical Society of New Jersey, and Mr. Richard I. Nevin, Executive Officer of the Society. Dr. Butler brought the members present up-to-date on the current status of state level planning for the establishment of a Class A medical and dental school in New Jersey, and stressed the broad function of a modern medical teaching center in assuring for the future professional personnel trained to the highest standards. The actual training of a few more doctors and dentists was envisioned as only a small, albeit important function, of the medical teaching school and hospital which automatically come to serve as the educational center for all the many more workers in health fields related to medicine and dentistry.

Dr. Emanuel M. Satulsky presided and before adjournment the following new members were welcomed into the society: Eugene C. Hohenstein and John Loeffler, Jr. of Westfield; Theodore Z. Lorenc of Mountainside; Warren B. Nestler and Frank D. Newell of Summit; J. Gerald Pearson of Elizabeth; and James W. Weigel of Plainfield. Emile H. Boselli of Fanwood and George F. Kamen of Westfield were accepted as transfers from the Hudson County and New York County Medical Societies respectively.

NEW JERSEY RHEUMATISM ASSOCIATION

Cyril M. Canright, M.D., Reporter

The *New Jersey Rheumatism Association* held a scientific meeting and discussion at the Academy of Medicine of Northern New Jersey, in Newark, November 19, 1952.

Two papers were presented under the general subject of the "Present Status of Therapy in Arthritis". Dr. Otto Steinbrocker, Associate Clinical Professor of Medicine, New York University, outlined the toxic manifestations and potentialities of "Butazolidin in the Treatment of Arthritis", along with its remarkable analgesic properties. He warned against the indiscriminate use of Butazolidin until more data could be accumulated upon the hazards of its usage.

Dr. Charles A. Ragan, Associate Professor of Medicine, College of Physicians and Surgeons, presented the subject: "Intra-Articular Injections in the Treatment of Arthritis". He stressed the efficacy and prolonged effect of hydrocortisone (Compound F), especially in the intra-articular injections of the knee, stating that although he is usually known as a "prophet of doom", he felt that this product, physiologically, was a true anti-arthritic remedy. He revealed that it could be isolated in the body tissues after the injection of the more complex product, cortisone.

The chairman, Dr. W. Alan Wright, introduced the speakers, and later Dr. Peter Warter and associates, who led the discussion. President Clarence Whims closed the meeting after a very enlightening and interesting discussion.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Edward H. Dyer, Ventnor

With election day behind us, we can turn our thoughts to problems closer to home, but we need not forget that the women of the Auxiliary and women all over the country, again demonstrated what can be accomplished when we work together for a common cause.

Recently, at our fall Conference in Chicago, Dr. Howard, our liaison with the A.M.A., spoke to us about it now being a "favorable climate" in which to conduct our programs—that our doctors can continue, now, to do as they have always done—"treat patients and improve the health of the nation".

Our Auxiliary goal is better *Public Relations—Your Personal Responsibility.* Each member must know the who, the where, the why and the aims of the Auxiliary. Our programs must have local appeal and be a community service and none is too small to deserve recognition.

Again and again, as we visit the different counties, we realize the importance of the individual member. Each has a job to do and an opportunity to promote her interests. The county auxiliary is the contact—the liaison with other organizations. The state auxiliary is the clearing house.

If you have not had an opportunity to do so before, plan to attend the next State Board meeting in Trenton. Bring a group from your county to see our beautiful building, our own Auxiliary office, our fine staff, and meet some of the outstanding women in our group. I am sure you will find it a pleasant and profitable day.

We welcome and invite any suggestions or ideas you may have as to how we can augment our program and we stand ready to aid or help you in any way that we can. *This is your Auxiliary.*

AUXILIARY REPORTS

Atlantic County

Mrs. Harry P. Goodman,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Atlantic County Medical Society* held its first Fall meeting October 10, 1952, at the Traymore Hotel.

The President, Mrs. F. Rolfe Westney, presided.

Dr. Robert Harley, president of the Atlantic County Medical Society extended greetings to the group and thanked all members for the good work they have done in the past. The honored guest for the evening was Mrs. Edward H. Dyer, President of the Woman's Auxiliary to The Medical Society of New Jersey.

The auxiliary at this time also welcomed the wives of the members of the County Dental Society who attended the meeting.

Mrs. Clarence Whims gave a report on the chronically ill; stressing the need of a homemakers service which would assist in keeping long term patients out of the hospitals and institutions.

The Ways and Means committee, Mrs. Anthony Merendino, chairman, stated that the Auxiliary will hold a card party and fashion show January 27, 1953, at the Ambassador Hotel.

At the close of the meeting the Auxiliary members and guests joined the Medical Society in a buffet supper.

Cumberland County

Mrs. E. C. Greene,
Chairman, Press and Publicity

Mrs. Richard H. Demaree of Long Branch, State Chairman of the Rural Community Health Program, was guest speaker at the luncheon meeting of the *Woman's Auxiliary to the Cumberland County Medical Society,* held at the Cumberland Hotel mezzanine on October 2, 1952. Mrs. Demaree outlined the 11 subjects, on a new program set up by her committee, which are available for use at lay organization meetings, under sponsorship of the state or county auxiliary.

Dr. Mary Bacon, Chairman of the Rural-Community Health Committee of the Cumberland County Medical Society, urged the auxiliary to support Mrs. Demaree's program for the health and welfare of all people in mind.

Dr. Norman W. Henry of Vineland, President of the Cumberland County Medical Society, also attended the opening fall meeting and expressed the society's appreciation for the help the auxiliary lends.

Health conditions abroad were discussed by Mrs. Frank J. T. Aitken, who traveled in Europe this summer. The British National Health Plan was compared with our own type of medical practice.

Mrs. Edward Kelemen, President of the Wo-

man's Auxiliary to the Monmouth County Medical Society, was also a guest.

Mrs. A. B. Kump, President, conducted the business meeting at which time the following committee members were announced: Nurse Recruitment, Mrs. Samuel B. Pole, 3d, Chairman, Mrs. R. A. Levenson; Legislative, Mrs. Kenneth E. Corson; Rural-Community Health, Mrs. P. K. Ayars, Mrs. Anthony Pino and Mrs. A. D. Sewall to assist Mrs. Sherman Garrison, Jr.; Chairman Program Committee, Mrs. B. Berkowitz, Mrs. A. D. Sewall, Mrs. L. J. Kauffmann, Mrs. Peter E. Penico, Mrs. N. E. Marchione, Mrs. R. A. Levenson to assist Mrs. M. N. Harris; Chairman Hospitality Committee, Mrs. A. Palladino in charge of transportation.

Mrs. Charles Sharp of Port Norris was reported as the newest of the 55 members to date.

Essex County

Mrs. Louis L. Covino,
Chairman, Press and Publicity

On October 15, 1952, the *Woman's Auxiliary to the Essex County Medical Society* held their annual Public Relations Day at the Academy of Medicine, Newark. Mrs. Kenneth E. Gardner of Bloomfield, Public Relations Chairman, presented an excellent program to an interested audience of 150. Mrs. John Torppey of Glen Ridge was her Co-Chairman. Officers and members of many Women's Clubs, PTA groups and Hospital Auxiliaries were present.

Greetings were extended by Mrs. Edward Dyer, President of the Woman's Auxiliary to The Medical Society of New Jersey, Harrold A. Murray, M.D., President, Medical Society of New Jersey, Lewis W. Brown, M.D., President of Academy of Medicine, Nicholas A. Antonius, M.D., President of the Essex County Medical Society, and William H. Hahn, M.D., President-Elect of the Essex County Medical Society. Our President, Mrs. Jerome Kaufman, welcomed the guests.

"Your Part in Community Health" was the subject discussed by the panel. Frank Forte, M.D., First Vice-President of the Essex County Medical Society and Public Relations Chairman for The Medical Society of New Jersey, was the Moderator.

Mr. Edward L. Parker, Executive Secretary of Family Service Bureau of Newark, explained "The Welfare Agencies in Community Health" and Mr. F. Stanley Howe, Fellow of the American College of Hospital Administrators and Past President of the New Jersey Hospital Association discussed "The Role of The Hospital in Community Health". Kenneth E. Gardner, M.D., Past-President of the Essex County Medical Society and Public Health Chairman of The Medical Society of New Jersey covered "Medical Care in Community Health" and Samuel R. Kesselman, M.D., Attending Psychiatrist at Bordentown Reformatory and a Member of The International Congress of Criminology gave an interesting description of "Juvenile Delinquency in Community Health".

Many interesting questions were answered in the period following the panel.

The Hospitality Committee served dessert following the program. Mrs. C. J. O'Neill, Jr., of South Orange, Hospitality Chairman was assisted by Mrs. Thomas Santoro of East Orange, Reception Chairman and her committee. Mrs. Frances Just was in charge of Printing and Mrs. Louis Covino, Publicity.

Our Arts and Hobbies Chairman, Mrs. A. B. Iannone of East Orange has many members working at their hobbies. Among the interesting classes already underway are an oil-painting class under the direction of Mrs. John O'Sullivan of Arlington, a dress making class set up by Mrs. Frank Bellucci of Newark, and a very energetic group of wives have been able to inveigle their hubbies out to a weekly Ballroom Dance Class under the direction of Mrs. Anthony Biunno of East Orange. There is much interest being shown among all the groups and we are looking forward to our usual Arts and Hobbies Day in March.

Hudson County

Mrs. M. Dolganos, Publicity Chairman

The meeting of the *Auxiliary to Hudson County Medical Society* held November 3, 1952, in Murdock Hall, Jersey City Medical Center, was well attended. The president, Mrs. Albert Lepis, presided.

Mrs. John DiGiola, chairman of legislation, directed the program for Monday's meeting. An interesting feature of the program was a movie "Government Is Your Business".

The winner of the special prize awarded by the committee for the Supper Dance which took place on October 29, at Mayfair Farms, West Orange, N. J., was Dr. J. P. A. McCarron of Bayonne, N. J.

Mrs. Albert Lepis welcomed into the organization three new members—Mrs. Carolyn Jane Scott, daughter of Dr. and Mrs. Samuel Scott, Mrs. Harold W. Grossman and Mrs. A. A. Cinotti.

The Supper Dance which was held at Mayfair Farms, West Orange, was a very successful event —socially and financially. The proceeds go to the Auxiliary Scholarship Fund. Mrs. Sidney Chayes of Bayonne, and Mrs. Morris Bresev of Jersey City, were co-chairman.

The two day Hobby Show Exhibit, and musicale of the Hudson County Medical Society and the Auxiliary, opened on Saturday, November 8th in Murdock Hall, Jersey City Medical Center.

About forty exhibits from the doctors and their wives were on display in the showroom. A pencil sketch of President-Elect Dwight D. Eisenhower, made by Dr. S. Silvera of Arlington when he was serving under the General in Germany in 1945, was a distinguished feature of the exhibit.

The ship models built by Dr. Frank Spano of Union City were, as usual, outstanding.

Other exhibits including paintings in oil and water color, photography, handwork, and collectors' items were of general interest.

The show terminated on Sunday afternoon with the musicale. Piano selections were played by Miss Lillian Silvera, daughter of Dr. S. Silvera of Arlington, and nine year old Mary Ann Martin, granddaughter of Dr. and Mrs. C. B. Kelley. Dr. John Imhoff of Union City contributed violin selections

and Mrs. Edward Sciarci played the harp. Dr. Clement Jones of Bayonne was prestidigator. Dr. and Mrs. Louis Perkel were co-chairmen. Miss Ann Murphy, director of nurses, Jersey City Medical Center, was hostess. Dr. Joseph Donnelly, president-elect, Hudson County Medical Society, and Mrs. Albert Lepis, president of the Auxiliary, cordially welcomed the guests.

Middlesex County

Mrs. Vivian Krafchik, Publicity Chairman

The first meeting of the 1952-1953 season of the *Woman's Auxiliary to the Middlesex County Medical Society* was held on October 16, 1952, at Woodlawn in New Brunswick with Mrs. Norman Rosenberg presiding. Plans were formulated for the coming year. These include a Dinner Dance and Card Party with proceeds to be used for our Nurses' Scholarship Fund. At present we have three girls on Scholarship studying to be nurses at St. Peter's Hospital and Perth Amboy General Hospital and are planning to offer a fourth scholarship in January 1953.

Mrs. Stewart Alexander of Park Ridge, state public relations chairman of the Auxiliary to the State Medical Society, spoke to the group on the proposed Medical-Dental College in New Jersey, from the point of view of its needs, methods of financing, site and publicity for the people of the state.

Jean, Gerald and Geraldine Pellegrino of Perth Amboy entertained with accordion selections and four new members were introduced to the group.

BOOK REVIEWS

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of Northern New Jersey

Gynecologic and Obstetric Pathology. By Emil Novak, M.D. Third Edition. Pp. 595 with 630 illustrations, 19 in color. Philadelphia, Saunders, 1952 ($10.00)

This third edition of this book is so far superior to the others that it is practically a new volume. Dr. Novak has been so long associated with this subject that it has practically become a part of him. He brings the material up to date. Each part of the female generative organs is systematically arranged according to histology, inflammatory reactions, degenerative changes, proliferative changes, benign and malignant neoplasms. Each subject is well documented with a complete bibliography.

The illustrations are ample and excellent. Most of them are photographs which are much superior to drawings.

Of particular interest is the normal histology of the cervix under various conditions, some of which might be mistaken for neoplastic proliferation.

In addition to being a text, this book contains a sufficient number of illustrations so that it may be considered an atlas of gynecologic pathology. There is an excellent classification of ovarian neoplasms. A chapter on the pathology of the breast has been added to this edition, which will be found to be of great value to the general practitioner, the gynecologist, and to the pathologist.

SAMUEL A. GOLDBERG, M.D.

Cardiography in General Practice. By Abraham I. Schaffer, M.D. Pp. 135. Baltimore, Williams and Wilkins Co., 1952 ($3.00)

Electrocardiography has become such a highly developed branch of cardiology, that it is almost a specialty in itself. Ponderous tomes have been written about it, and the medical journals are replete with additional observations constantly being compiled. It is therefore refreshing to find a clear, well-written distillation of the major principles of electrocardiography presented as ably as is done in this small book by Dr. Schaffer. In addition to summarizing the science of electrocardiography, short chapters on vectorcardiography and ballistocardiography justify its all-inclusive title.

As stated by the author in the foreword, this book is neither a textbook nor an atlas. It is brief, and sketches in broad outlines the essentials of electrocardiography. It is written primarily for medical students, anesthetists, physiologists, and general practitioners, and provides a sound foundation for one who wishes later to delve more deeply into this branch of diagnosis.

After a short introduction to electrocardiographic technic, there is an excellent chapter devoted to the electrical behavior of the heart, with a specially lucid explanation of the "dipole", and of electrical vectors. In fact, the vector approach is utilized throughout the book to clarify empirical electrocardiographic findings. A series of chapters then considers the arrhythmias and intracardiac conduction defects, following which are chapters devoted to specific chamber hypertrophy, myocardial infarction and anoxia, and pericarditis. The effects of digitalis and metabolic disorders are next considered, followed by one on vector interpretation. There is a superb chapter on the definition of electrocardiographic abnormalities, which precedes the last two chapters on vectorcardiography and ballistocardiography.

Certain portions of the book are outstanding, such as the criteria for an abnormal Q wave, in chapter

17. Some of the theoretical considerations conflict with advanced thinking on the particular topic in question, but this does not impair the value of the book from the clinical standpoint.

This book can be highly recommended for novices in electrocardiography, and as a top-notch review of basic principles for those with more training and experience.

R. D. Goodman, M.D.

Pharmacology in Clinical Practice. By Harry Beckman, M.D., Director, Departments of Pharmacology, Marquette University Schools of Medicine and Dentistry. Pp. 839. Philadelphia, W. B. Saunders Company, 1952 ($12.50)

There are only a few modern books available to the student of medicine and the practicing physician dealing with the important subject of pharmacology. Even fewer are the volumes on the shelves treating this topic from the practical clinical viewpoint, rather than with the theoretical systematic teaching of yesteryear. It is, therefore, a pleasure to welcome Beckman's new "Pharmacology in Clinical Practice" written by a scientist who is thoroughly at home in both clinical medicine and pharmacology; and who orients his material in terms of symptoms and specific diseases, not according to chemical groupings of drugs.

This book is comprised of two sections. The major part of the text deals with the pharmacologic aspect of all branches of clinical medicine as well as dentistry. Internal medicine, with its various ramifications, is treated most extensively, each organ and organ system, receiving a separate chapter. This is followed by neuropsychiatry, obstetrics, gynecology, pediatrics, the surgical specialties, ophthalmology, otorhinolaryngology, and venereology. Only five special chapters remind the reader of the former orthodox texts of pharmacology; chapters in which pharmacologic considerations outweigh the clinical, i.e. allergy, anesthesia, autonomic nervous system, antibiotics, and sulfonamides.

Section two, which comprises less than 10 per cent of the entire book, supplies a few chemical and physical facts about the drugs discussed in section one, and lists some representative commercially available preparations of the various pharmaca.

Everybody is familiar wih Beckman's "Treatment in General Practice", the last (6th) edition of which appeared in 1948. The present "Pharmacology" supplements the former book in many chapters and supersedes it in others. The text is completely up-to-date, concise, and logical; the diction is simple and easily comprehensible. It will prove to be indispensable to medical students, as well as practicing physicians and dentists, to teachers as well as research workers; and should not be absent from the bookshelves of any medical man.

William Nyiri, M.D.

Pardon My Sneeze. By Milton Millman, M.D. Pp. 217, San Diego, California, Frey & Smith Ltd., 1952.

You would think that the title "Pardon My Sneeze" refers to a book on hay fever. However, hay fever is only a small part of the material discussed in this 217-page paper-covered volume. The book is written for the allergic patient so that he may better understand his illness and, as a result, cooperate more efficiently with his doctor. The "why's" of skin testing and treatment are well explained.

Dr. Millman aptly converts the medical jargon of allergy to the language of the layman. Hay fever, seasonal and perennial asthma, eczema, urticaria and miscellaneous allergic diseases are described in simple terms.

How many times have you explained to a patient exactly what he must do at home and then you find at the next visit that he remembered little of your directions? It's much wiser to give out printed directions and if it's directions on how to minimize contact with dust or prepare a wheat-free diet—you'll find it well-covered in this volume.

The author puts too much stress on the importance of food allergy in the production of diseases of allergy. He mentions that he and his wife get allergy symptoms from food ingestion. Perhaps this is the reason.

If you can persuade your allergy patients to read this book, they will know a lot more about their illnesses and you will have more time to improve your number seven iron shot.

Frank L. Rosen, M.D.

Cornell Conference on Therapy. Volume V. Edited by Doctors H. Gold, D. P. Barr, F. C. Ferguson, Jr., McK. Cattell, F. Glenn, and G. Reader. Pp. 299. New York, The Macmillan Company, 1952. ($4.00)

There are fifty-one participants in these conferences. Among the subjects adequately and informatively discussed are: treatment of cough, management of fever, indications for vitamin therapy, treatment of obesity, low cholesterol diet and atherosclerosis, use of sedatives and narcotics, treatment of chronic muscular diseases, treatment of acute arterial occlusion, treatment of pneumonia, and treatment of bacterial meningitis.

This little practical volume should be of interest, and of some help to interns, medical students, and busy general practitioners.

Hyman I. Goldstein, M.D.

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Editorial Office
315 West State Street
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† Obituary
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ABSTRACTS

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THE PROBLEM OF THE SO-CALLED "GOOD CHRONIC" CASE OF PULMONARY TUBERCULOSIS

By the Committee on Therapy, American Trudeau Society, The American Review of Tuberculosis, May, 1952.

DEFINITION. An exact definition of the term "Good Chronic" is difficult. While no chronic tuberculosis is good, the term is retained because past usage has given it meaning which is difficult to encompass in any other succinct term. The term carries the following implications: (1) Extensive tuberculosis of many years standing is present. This is usually bilaterally distributed. (2) Disease is reasonably well stabilized. Evidences of instability are usually rather minor and transient. (3) Chronic cavitation is commonly present and is often bilateral. Pathologically, the remaining tissue changes are deemed to be predominantly fibrotic with necrotic foci limited in size, generally well circumscribed, and not in the stage of rapid liquefaction. Emphysema is common. (4) Cough and expectoration are variable but common symptoms. The condition of the patient is usually reasonably good. Systemic symptoms are absent or, at most, are occasional. Limited respiratory reserve is the rule but not marked dyspnea. (5) Tubercle bacilli are present in the sputum or gastric specimens either constantly or intermittently. (6) Patients who may be included in the "Good Chronic" category vary considerably in their amenability to treatment, in the amount and kind of therapy already received, and in the prognosis. In many hospitals and clinics the term carries the implication that the patient is not readily amenable to cure, at least bacteriologically by the procedures in use, and that prolonged bed rest and other appropriate therapy have already been tried and have failed to achieve the goal of "inactive" tuberculosis.

THE PROBLEM. The problem is world-wide and well known. Some of the salient aspects are: (1) The patient may be reluctant to accept hospitalization and treatment. Such a patient may feel well and be quite unconcerned by the "cigarette cough" or "chronic bronchitis" which he has had for years. (2) For most patients and their families, a prolonged incapacitating illness becomes increasingly burdensome. Discouragement, boredom, and resentment are common reactions. Such patients often leave sanatoriums and hospitals against medical advice; others remain and exert a disturbing and discouraging influence upon other patients. (3) A hospital bed may be occupied for years by one "Good Chronic" patient. Hospital facilities are absorbed which could serve for the successful treatment and cure of several patients with less refractory types of tuberculosis. Thus, patients with extensive chronic tuberculosis constitute a major obstacle to efficient utilization of tuberculosis hospital facilities. (4) Patients in this category entail a considerable financial burden upon the community. (5) On the other hand, failure to hospitalize these patients, or discharging them back home and into the community creates other problems, for example: (a) the patients are generally infectious and may transmit tuberculosis to others; (b) many remain well clinically only under very sheltered conditions; (c) as a result, working capacity and ability to obtain satisfactory employment are extremely limited.

THE SOLUTION. No really satisfactory solution to the over-all problem has been devised. The best attack lies in prophylaxis, in finding tuberculosis early before it has become extensive and chronic and in hospitalizing promptly and treating ade-

quately all patients with active disease. Present experience clearly demonstrates, however, that such prophylaxis is still far from eliminating the problem of the "Good Chronic" case in the immediately foreseeable future.

No single plan of attack is equally applicable to all patients or to all situations. Individualization is necessary in the management of all tuberculous patients including "Good Chronics". This belief in individualization is implicit throughout the following generalizations:

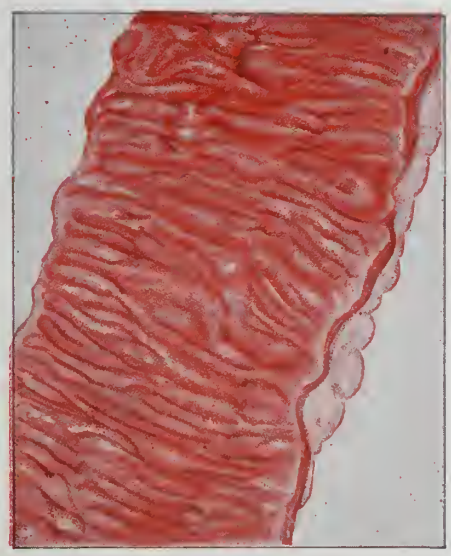
A. Home care: Whether patients with "Good Chronic" tuberculosis should be kept in the tuberculosis hospital or handled at home must be decided individually for each case. Elements which deserve to influence this decision are: (1) Medical and surgical considerations affecting the particular patient at hand; (2) The economic circumstances, the intelligence, and the attitudes of the patient and his family; (3) Circumstances in the community.
B. Special institutions: The advantages of special institutions and sheltered communities, as compared with the regular tuberculosis hospital, are: (1) Less medical and nursing care need be provided; (2) It is feasible to allow the patients more privileges, thus making a prolonged stay more acceptable; (3) Graded amounts of productive work can be assigned making such a place, in part, self-supporting; (4) Beds in regular tuberculosis hospitals are freed for other patients.

There are several deficiencies and disadvantages to this approach: Few such places exist at present. Few patients are willing to accept transfer when this implies that reasonable hope for definitive cure has been abandoned. Few competent tuberculosis physicians are willing to confine their work solely to patients with extensive chronic disease. Removal of "Good Chronics" from competent medical supervision removes the most important factor which may lead to eventual cure and rehabilitation.
C. Care in a regular tuberculosis hospital: Continued hospitalization in a regular tuberculosis hospital or sanatorium appears to be the procedure of choice in the management of the great majority of "Good Chronics". This does not preclude the assignment of these patients to certain wards or sections of the hospital where medical and nursing care is less intensive than on other wards, where complete self-care is the rule, where special privileges can be granted, and where special activities in the field of occupational and diversional therapy and rehabilitation can be conducted. These wards should, however, be an integral part of the regular hospital, with systematic supervision by the regular medical and nursing staffs. The reasons are: The prompt recognition and treatment of exacerbations of tuberculosis are important if further deterioration in the patient's status is to be avoided. These patients also need competent medical care of collateral diseases and of intercurrent illnesses. The patient who is not amenable to successful treatment today may become amenable tomorrow.

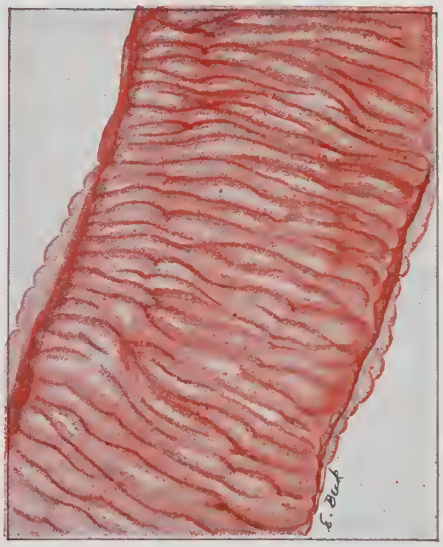
Modern treatment of any type of tuberculosis requires team work, to which the physician, the surgeon, the anaesthetist, various laboratory workers, and the rehabilitation team all make important contributions. Such team work is seen at its best in the well-integrated tuberculosis hospital.
Conclusion. The principal objective in the management of patients with "Good Chronic" tuberculosis is the actual cure and rehabilitation of as large a proportion as possible. The proportion amenable to cure is growing steadily as new therapeutic attacks are developed, and there is good reason to hope that this proportion will grow still larger as progress in therapy continues. The full advantages of this trend are most likely to be realized in the regular tuberculosis sanatorium or hospital. While other alternatives frequently deserve consideration in individual instances, the best general policy is continued hospitalization of patients with "Good Chronic" tuberculosis in regular tuberculosis units, hospitals, or sanatoriums.

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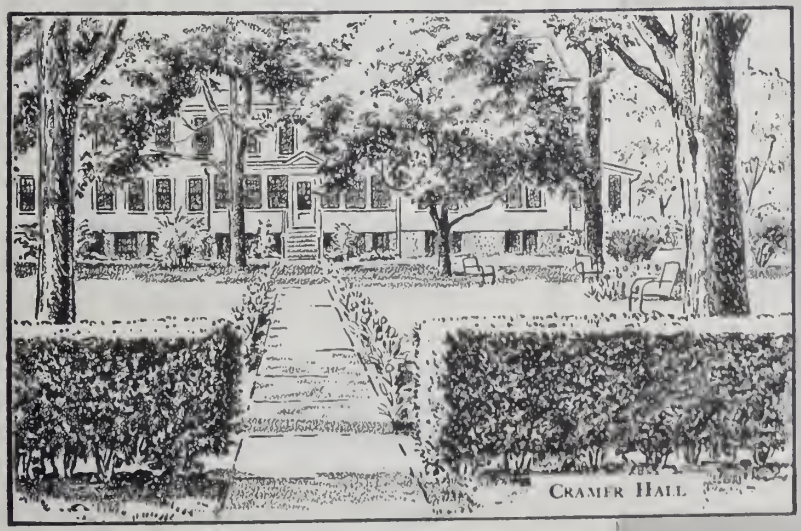
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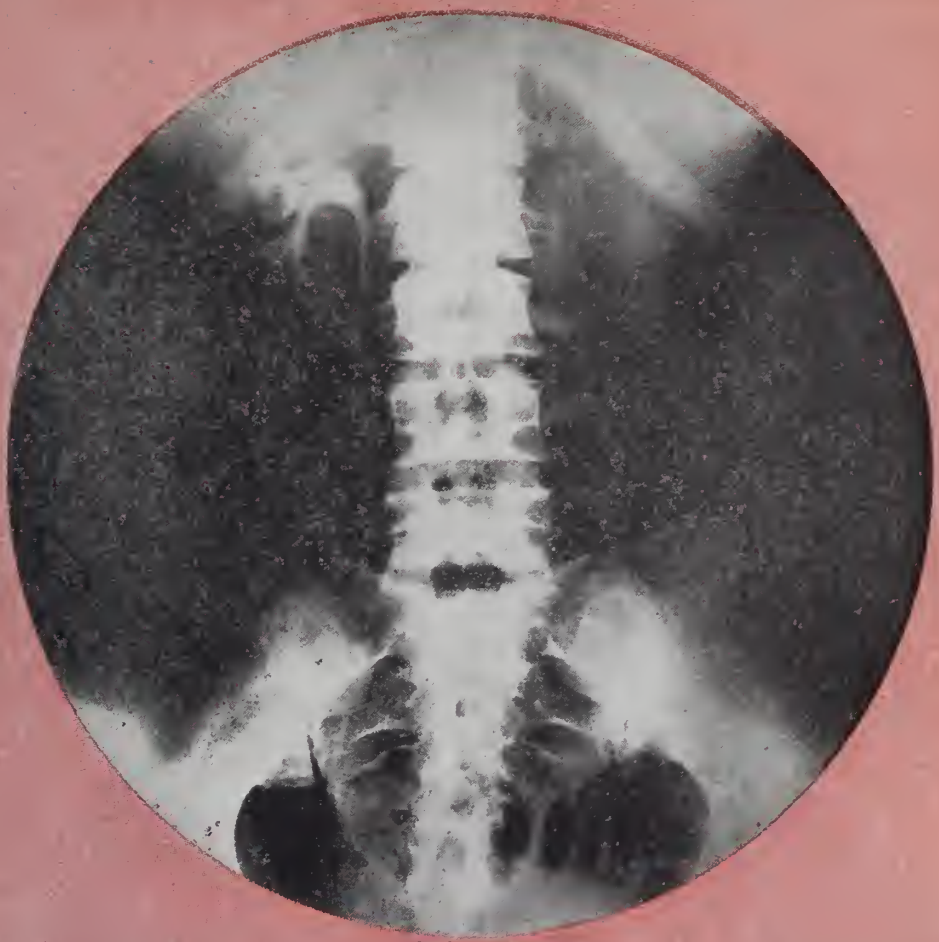
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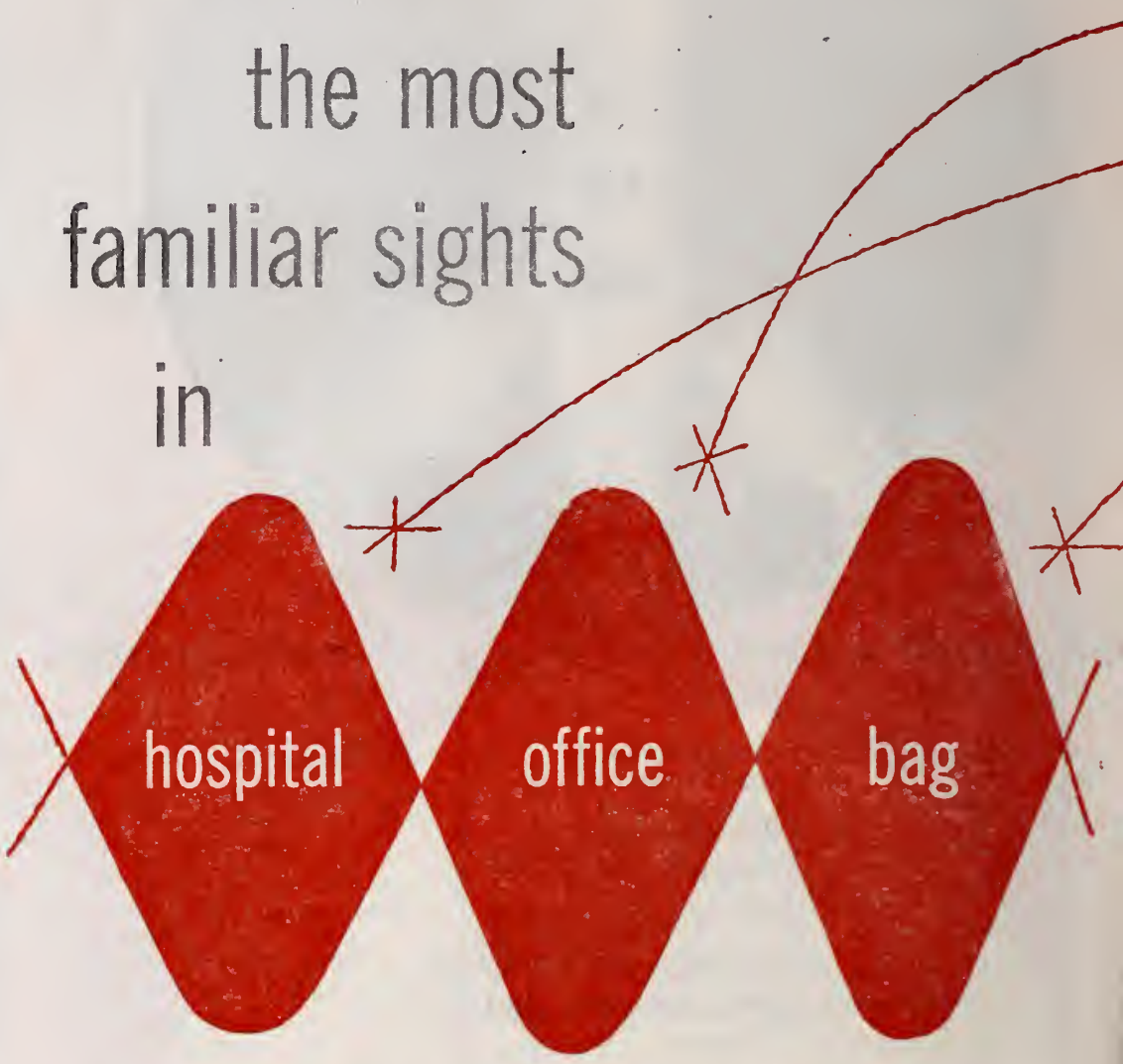
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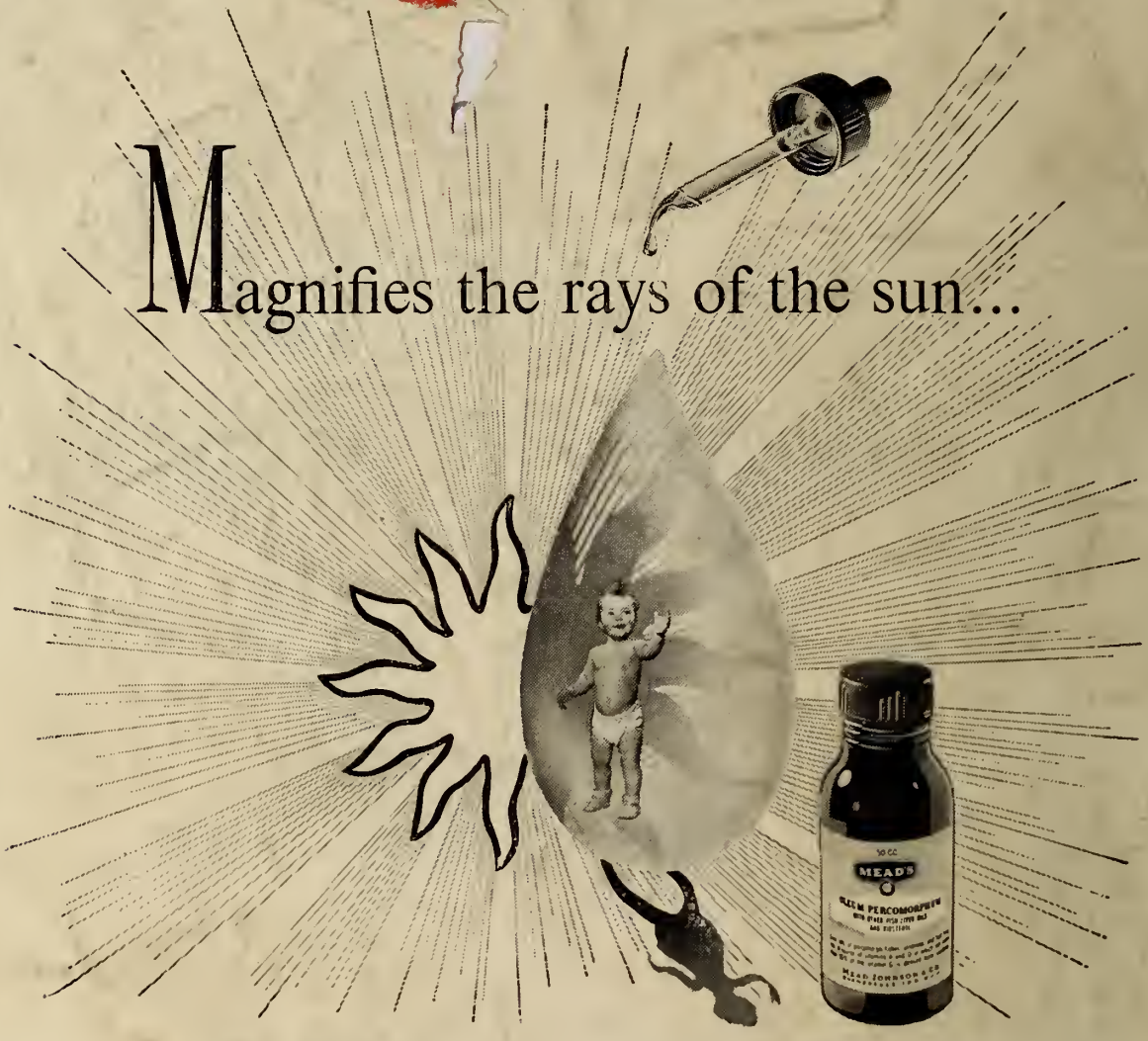


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OF

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Haddon Hall, Atlantic City, New Jersey, May 19, 20 and 21, 1952

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THE MEDICAL SOCIETY OF NEW JERSEY

Monday Morning Session—May 19, 1952

The One Hundred Eighty-sixth Annual Meeting of the House of Delegates of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, N. J., at 10:10 a. m., Dr. Sigurd W. Johnsen, President of the Society, presiding.

President Johnsen: I am very happy to open this 186th Annual Meeting of the House of Delegates of The Medical Society of New Jersey. This has been a momentous year, and I wish to thank all of the officers, Trustees, committees of the Medical Society for their wonderful cooperation during this entire year.

The office staff as usual, with Mrs. Madden as Administrative Secretary and Mr. Nevin as the Executive Officer, have carried out a wonderful program of coordinated effort.

One of the disappointments of this year was the passage of S-139 by both the Senate and the Assembly. This was passed in spite of all the opposition the Medical Society could muster and in spite of the excellent work of our Subcommittee on Legislation. Since its passage every effort has been made to induce Governor Driscoll to veto the measure, which we hope he will do.

We have brought about a closer relationship this year with our allied professions—law, dentistry and the hospitals—through liaison committees of our respective boards of trustees and we are now able to present a united front and together we hope to solve some of our mutual problems.

I now call this House to order and inquire of the Secretary whether there is a quorum.

Secretary Greifinger: Mr. President, there is a quorum present.

President Johnsen: The Reference Committee on Credentials. Dr. Crowe, any contested delegates?

Dr. Crowe: No contested delegates, Mr. President.

President Johnsen: I shall then appoint Dr. David B. Allman as parliamentarian, and two Sergeants-at-Arms, Dr. Benjamin F. Lee and Dr. George A. Corio.

We are now ready for a motion to adopt the minutes of the 1951 Annual Meeting, of which you have all received a copy.

Dr. Jerome G. Kaufman (Essex): I so move you, Mr. President.

Dr. Asher Yaguda (Essex): I will second the motion.

President Johnsen: It has been moved and seconded that the minutes as distributed be accepted. Any discussion? All in favor signifiy by saying "Aye". So ordered.

I now take great pleasure in introducing Dr. John G. Carr, Secretary of the New Jersey State Dental Society. This year we have had a splendid cooperative relationship with our dental society and particularly with respect to efforts to bring about the formation of a medical-dental school in New Jersey.

It gives me great pleasure to introduce Dr. John G. Carr, Secretary of the New Jersey State Dental Society. (Applause)

Dr. John G. Carr: Dr. Johnsen, Members of the House of Delegates: It is indeed a pleasure for me to bring greetings from the New Jersey State Dental Society, and also to wish you a successful and enjoyable meeting. The formation of the Medical-Dental Liaison Committee has probably resulted in the greatest period of cooperation and understanding between our two professional organizations. This is as it should be. We have many common problems which can be solved only by representatives of our two associations sitting down together and discussing them and seeking a solution.

I am particularly pleased to be able to accept your hospitality and to meet with you and wish you Godspeed. (Applause)

President Johnsen: Thank you, Dr. Carr. You now have had handed you the Annual and Supplemental Reports, and a motion to refer these to the reference committees is in order, unless anyone wishes detailed information on any of the reports.

We have changed our time for the reference committees to the daytime hours where we hope we will have thorough discussion in all these reference committees of these various reports. Please make it a point to go to the reference committee which is reviewing any report in which you are interested. Discuss it thoroughly so that the committee can give due consideration to all of these matters.

Hearing no suggestion for a discussion, I will entertain a motion to accept the Annual and Supplemental Reports for further reference.

Dr. Kaufman (Essex): Mr. President, I so move you.

Dr. Wilentz (Middlesex): I second the motion.

President Johnsen: Any discussion? All in favor signify by saying "Aye". They will then be referred to the respective reference committees for thorough discussion.

Are there any additional supplemental reports not included in the material already submitted? Hearing none, I now call for new business.

Dr. R. J. Cottone (Mercer): I wish to read the following resolution from the Mercer County Medical Society:

Whereas, the action of the Mercer County Component Medical Society in going on record at its meeting on April 9, 1952, as opposing any form of fee splitting, is regarded as appropriate and within its rights; and

Whereas, the Mercer County Component Medical Society further believes The Medical Society of New Jersey should take definitive action concerning fee splitting. Therefore be it

Resolved, that The Medical Society of New Jersey go on record as reaffirming its belief in its present high standard of medical ethics. And be it further

Resolved, that The Medical Society of New Jersey go on record as being unalterably opposed to any form of fee splitting or division of fees, under any guise, and by whatever terms described wherein a physician is to receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services. On the contrary, it shall be agreed that all fees shall be collected and retained by the original physician in accordance with the value of services rendered, whether or not such services be paid for directly by the patient or by any insurance company or agency designated for the purpose of such payment. And be it further

Resolved, that all members of The Medical Society of New Jersey immediately disassociate themselves from participating in or cooperating with any insurance plan or company, agency, association or staff condoning, permitting or promoting fee splitting in any form. And be it further

Resolved, that any member continuing this unethical practice be subject to the penalty of expulsion from The Medical Society of New Jersey.

Dr. Cottone: I move that this be referred to the proper reference committee.

Dr. John F. Johnson (Mercer): I second the motion.

President Johnsen: Any discussion? All in favor say "Aye". Contrary? Passed. I refer this resolution to Reference Committee "C".

Dr. Paul J. Kreutz (Union): Here is a resolution passed by the Union County Medical Society:

Whereas in view of the increased cost of the maintenance of a medical practice today, the Union County Medical Society adopted and passed a resolution in January 1952 which established a minimum fee basis of $5.00 for the initial office visit and $4.00 for subsequent visits for compensation cases.

Therefore Be It Resolved that in order to establish an equal and uniform basis in all counties of the State that this schedule be presented to The Medical Society of New Jersey and be upheld in all the county societies.

Dr. Kreutz: I move that this be referred to Reference Committee "E".

Dr. E. M. Satulsky (Union County): I second the motion.

President Johnsen: All in favor say "Aye". All opposed, "No". Passed and referred to Reference Committee "E".

Dr. Edward H. Albano (Essex): I have a resolution from the New Jersey Society of Clinical Pathologists which I shall now read:

Whereas, an application is presently being processed with the intent of obtaining A.M.A. approval of a specialty board in medical microbiology which will certify non-physicians as diplomates in a field of medical practice, and

Whereas, there is already in existence an American Board of Pathology which can provide certification of properly qualified physicians in the field of medical microbiology, now, therefore be it

Resolved, that the House of Delegates reaffirm its approval of the essentials for an approved examining board in a medical specialty, including the principles that applicants for examination must be graduates of a medical school approved by the Council on Medical Education and Hospitals and must be licensed to practice medicine; and be it further

Resolved, that the House of Delegates instruct the Council on Medical Education and Hospitals to limit its approval of Specialty Boards to those which can comply with these essentials, in order to safeguard the interests and welfare of patients; and be it further

Resolved, that the delegates of The Medical Society of New Jersey to the American Medical Association be instructed to place these resolutions before the June 1952 convention of the House of Delegates of the American Medical Association.

Dr. Albano: I move that this be referred to proper reference committee.

Dr. Yaguda: Second the motion.

President Johnsen: Any discussion? All in favor signify by saying "Aye". So ordered. I will refer this resolution to Reference Committee "E".

Dr. E. M. Satulsky (Union County): I have a resolution to read. Here it is:

The Union County Medical Society wishes to inform the House of Delegates of The Medical Society of New Jersey that it deplores the fact that M.D. automobile license plates have been issued to individuals not members of The Medical Society of

New Jersey, and requests that the House of Delegates recommend that the Director of Motor Vehicles of New Jersey be authorized to issue such distinctive plates only to physicians holding the degree of "Doctor of Medicine" from a medical school acceptable to the New Jersey State Board of Medical Examiners.

DR. SATULSKY: I move that this be referred to the Committee on Miscellaneous Business.

DR. H. S. MURPHY (Union): I second the motion.

PRESIDENT JOHNSEN: All in favor? All opposed? I hear some "Nays". Let's have a show of hands. All in favor? Contrary minded? The "Ayes" have it and the resolution will be referred to the Committee on Miscellaneous Business.

DR. L. K. COLLINS (Gloucester): The Gloucester County Medical Society asks favorable consideration for the following resolution:

WHEREAS, recently two bills (S-139 and S-210) opposed by The Medical Society of New Jersey, passed both houses of the New Jersey Legislature; and

WHEREAS, most members of The Medical Society of New Jersey are too busy practicing medicine to devote any appreciable time to political maneuvers in Trenton; and

WHEREAS, there is apparently a distinct need for a full-time medical representative in Trenton to protect The Medical Society of New Jersey, and the high principles for which it stands;

THEREFORE BE IT RESOLVED, that the House of Delegates at this meeting urgently request the Board of Trustees to consider favorably the employment of a full-time adequately-paid medical representative in the State of New Jersey; and

BE IT FURTHER RESOLVED, that the House of Delegates make adequate allowance for such a necessary expenditure in next year's budget, to be approved at this meeting, in order to obviate the usual lapse of one year before activating such an important measure.

DR. COLLINS: Mr. President, I move this resolution be referred to the appropriate reference committee.

DR. A. GUY CAMPO (Gloucester): Second the motion.

PRESIDENT JOHNSEN: Any discussion? All in favor signify by saying "Aye". Contrary? (There were several Noes.) The "Ayes" have it, and I so declare it. This I refer to Reference Committee "E".

DR. L. B. ARMSTRONG (Union County): Union County has two more resolutions. The first is simply this: "Be it resolved that an open meeting be held annually to discuss problems of the Medical-Surgical Plan". I move you, Mr. President, that this be referred to Reference Committee "C".

DR. P. J. KREUTZ (Union): I second that motion.

PRESIDENT JOHNSEN: All in favor? All opposed? The motion is carried and that resolution will be referred to Reference Committee "C". You had another Union County resolution?

DR. ARMSTRONG: Yes. Here it is:

WHEREAS the federal government for many years has built Veterans Hospitals throughout the United States to take care of service connected disabilities. Since the last war, there has been a tremendous building program for Veterans Hospitals in the United States. Many of these have been built in remote and out of the way locations. The expense of building and operating these hospitals has been much higher than the domestic hospitals.

WHEREAS there has been a policy developed where the entire family and other relatives of the veteran may be cared for in these Veterans Hospitals at the expense of the taxpayer.*

WHEREAS in view of the probable acceptance of universal military training in the United States, it will be easy for all personnel so connected to be classified as veterans.

WHEREAS the A.M.A has vigorously opposed socialized medicine it will be very easy for the government to force socialized medicine upon the physicians and the taxpayers by the further building and operating of the veterans hospitals, without actual congressional approval.†

BE IT RESOLVED that organized medicine vigorously oppose the expansion of medical care to veterans' families and relatives, and that such medical care be strictly limited to service connected medical disabilities to the veteran himself.

BE IT RESOLVED that a copy of this resolution be presented to The Medical Society of New Jersey for adoption and presentation to the A.M.A. for action.

DR. ARMSTRONG: I move that this be referred to Reference Committee "E".

DR. HARRIS (Union): I second the motion.

PRESIDENT JOHNSEN: In favor? Opposed? Carried and referred to Reference Committee "E". Any more new business? If not, let me read a telegram just received:

"Greetings to you and the incoming-President from the American Medical Association. Also best wishes to the House of Delegates for a successful convention. Louis H. Bauer, President-elect of the A.M.A." (Applause)

I have here also a memorial which I would like to read and then we will receive any further memorials from the House.

"This year Dr. Chester I. Ulmer resigned as a member of the Judicial Council for the Fifth Dis-

* Relatives of a veteran are not eligible for admission to a VA hospital unless they happen to be war veterans themselves—Editor.

† No VA hospital can be erected, staffed or operated without congressional approval—Editor.

trict. The Board of Trustees accepted Dr. Ulmer's resignation with very real regret.

"For a decade and a half the efficiency of the Council has been increased and its dignity enhanced through the actions and influence of Dr. Ulmer. He is a man of such prowess of intellect and such gentility of heart that of him it can truly be said all that he touched he adorned.

"We of The Medical Society of New Jersey are deeply indebted to him for the gifts of his mind and his heart. The imprint of his contribution is a mark of distinction upon the life and accomplishments of our Society. His have been generous gifts of self, which we shall long delight to remember.

I move you, gentlemen, a rising vote of thanks to honor a gentleman of personal and professional distinction—Dr. Chester I. Ulmer.

(The members arose and applauded.)

President Johnsen: Are there any other memorials from the floor? Are there any other memorials? I hear none.

You have received a copy of the proposed amendments to the Constitution and By-Laws, which, by vote, you have referred to the proper reference committee. However, at this time I will entertain a motion for any other amendments to the By-Laws or Constitution from the floor, if there are any such to be presented. Hearing none, I assume that here are no amendments.

Are there any other matters of business to come before this House at this time?

The Trustees have passed a number of resolutions, copies of which were distributed among you. For the record, I shall read them now, so that you may be familiar with them and discuss them with the appropriate reference committee. I am also appointing Dr. Benjamin F. Lee as an alternate member of Reference Committee "C" so that you may mark your programs accordingly.

Here are the resolutions adopted by your Trustees recently:

1. Whereas, the prevailing method of billing the membership separately for their A.M.A. membership dues through the Executive Offices of the State Society involves reduplication of efforts,

Whereas, the billing for county, state, and A.M.A. membership dues could readily be made by county societies and the monies transmitted to the A.M.A. through the State Society,

Be It Resolved, that the Board of Trustees of The Medical Society of New Jersey recommends to the House of Delegates that the county societies be directed hereafter to collect the A.M.A. dues.

Referred to Reference Committee "B".

2. Whereas, for the work entailed in the collection and recording of A.M.A. membership dues, The Medical Society of New Jersey presently is compensated at the rate of one per cent (1 per cent) of the total monies involved, and

Whereas, the cost to The Medical Society of New Jersey for this work approximates three and one-half to four per cent (3½ to 4 per cent) of the total monies involved,

Be It Resolved, that The Medical Society of New Jersey respectfully requests that the American Medical Association make an equitable upward revision of the rate of compensation for the work of dues collection or release The Medical Society of New Jersey from the obligation of further collection of dues for the national organization.

Referred to Reference Committee "B".

3. The Board of Trustees of The Medical Society of New Jersey recommends the following nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey:

Charles W. Barkhorn, M.D., Irving P. Borsher, M.D., Lewis W. Brown, M.D., Harry N. Comando, M.D., Samuel A. Cosgrove, M.D., William F. Costello, M.D., William E. Dodd, M.D., Arthur W. Lunn, Royal A. Schaaf, M.D., Rudolph G. Schretzmann, M.D., Edward W. Sprague, M.D., John S. Thompson, Thomas J. White, M.D., Carl K. Withers.

Referred to Reference Committee "C".

4. The Board of Trustees of The Medical Society of New Jersey recommends the following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey:

Harry N. Comando, M.D., Samuel A. Cosgrove, M.D., William F. Costello, M.D., Arthur W. Lunn, Royal A. Schaaf, M.D., Rudolph C. Schretzmann, M.D., Edward W. Sprague, M.D., John S. Thompson.

Referred to Reference Committee "C".

5. The Board of Trustees received the following resolution from The Society of Surgeons of New Jersey through Dr. W. H. McCallion, Secretary, and refer the resolution to the House of Delegates for consideration:

"Resolved, The Society of Surgeons of New Jersey regrets the failure of the Medical-Surgical Plan to adhere to the fee schedule previously agreed upon between the Medical-Surgical Plan and a Committee from the Society of Surgeons; and

"Be It Further Resolved, that the entire matter of the failure of the Medical-Surgical Plan to adhere to the agreement be placed before the proper authorities of The Medical Society of New Jersey as the parent body of the Medical-Surgical Plan."

Referred to Reference Committee "C".

6. The following resolution is approved by the Board of Trustees and referred to the House of Delegates for consideration:

Whereas, Medical Service Administration of New Jersey was organized in 1940 by The Medical

Society of New Jersey as an administrative agency to implement the objectives of The Medical Society in improving the distribution of medical care to the indigent and to persons of low and moderate incomes in New Jersey, and

WHEREAS, the Medical Service Administration of New Jersey has provided a practical demonstration of the possibility of providing adequate and satisfactory medical service to indigent and medically indigent clients of the City of Newark on a fee for service and free choice of physician basis according to a plan which may readily be adapted to other communities in the State, and

WHEREAS, the Medical-Surgical Plan of New Jersey—an outgrowth of Medical Service Administration—is now providing voluntary prepayment medical service to more than three quarters of a million employed persons throughout the State of New Jersey, and

WHEREAS, the Medical Director of both Medical Service Administration and Medical-Surgical Plan has for years served concurrently as an officer of The Medical Society of New Jersey in the capacity of the Director of the Distribution of Medical Care, and

WHEREAS, during the entire period of the existence of Medical Service Administration, The Medical Society of New Jersey has contributed to the support of Medical Service Administration as a nonprofit agency of The Medical Society available to it for the promotion of its declared purpose,

NOW, THEREFORE BE IT RESOLVED, by the House of Delegates of The Medical Society of New Jersey in annual convention assembled at Atlantic City, May 21, 1952, that the Society continue to support the activity of the Medical Service Administration of New Jersey as it has done in the past; and that the Society continue to designate the Medical Director of Medical Service Administration and of Medical-Surgical Plan as its Director of the Distribution of Medical Care at a salary to be determined by the House of Delegates or the Board of Trustees of The Medical Society of New Jersey.

Referred to Reference Committee "C".

7. The Board of Trustees recommend the following amendments to the By-Laws to the House of Delegates:

Amend Chapter VIII, Section 2—delete "Committee on Scientific Work", and

Section 6—delete complete section.

Amend Chapter X, Section 7—delete "and the Secretary of the Committee on Scientific Work".

Referred to Reference Committee on Constitution and By-Laws.

8. The Board of Trustees approve the following recommendation and recommend its approval by the House of Delegates:

That the 187th Annual Meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City, on May 18-21, 1953.

Referred to Reference Committee on Miscellaneous Business.

9. The following resolution is approved by the Board of Trustees and referred to the House of Delegates for consideration:

WHEREAS, the American Medical Association and the American Dental Association favor proper fluoridation of public water supplies to greatly reduce dental caries and thus to enhance dental health, and

WHEREAS, the State Department of Health requires approval of medical and dental societies, in addition to acceptable engineering data, before granting permission to fluoridate a public water supply, therefore

BE IT RESOLVED, that the House of Delegates of The Medical Society of New Jersey approve the fluoridation of public water supplies in this State, under regulations promulgated by the State Department of Health, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the State Commissioner of Health.

Referred to Reference Committee on Resolutions and Memorials.

DR. JOHN S. MADARA (Salem): May I read a resolution adopted by the Salem County Medical Society? Thank you. Here it is:

WHEREAS, The American College of Surgeons, the American Hospital Association and the American Medical Association have all adopted the policy that no general practitioner who is properly qualified to perform surgical and medical procedures in hospitals should be precluded from so doing because he is not eligible for certification, nor has been certified by any of the specialty boards, and

WHEREAS, the Board of Managers of the Salem County Memorial Hospital has recently adopted a policy limiting major surgical procedures to those eligible for certification or certified by specialty boards, and

WHEREAS, this is contrary to the policy of all our specialty boards; therefore be it

RESOLVED that the Salem County Medical Society go on record as being opposed to this policy adopted by the Board of Managers of the Salem County Memorial Hospital, and hereby request that the Hospital Committee of The Medical Society of New Jersey investigate this policy and effect measures to eliminate discrimination against properly qualified general practitioners.

DR. MADARA: I move that this be referred to Reference Committee "E".

DR. C. S. DAVISON (Salem): I second that motion.

PRESIDENT JOHNSEN: Discussion? All in favor? Contrary? Passed and referred to Reference Committee "E".

Are there any of our visiting delegates from other states present in the House? If not, I should like to read a letter from Dr. Oliver L. Stringfield:

"I regret most deeply that it will be impossible

for me to be present at the 186th Annual Meeting of The Medical Society of New Jersey, May 19 to 21. Circumstances over which I have no control make this impossible.

"I wish for your group the most successful meeting you have had. Your program is excellent and I know from past experience you will all be working for the best interest of medicine as a whole.

"My best wishes to the entire group. Oliver L. Stringfield."

I now see Dr. Barker in the room. Dr. Barker is the very able and effective Executive Secretary of the Connecticut Medical Society. I invite you to the platform, sir, and hope we may hear a few words.

Dr. Creighton Barker: Good morning, ladies and gentlemen. It is probably unnecessary for me to add anything to the letter which my neighbor, Oliver Stringfield, and perennial delegate from Connecticut has sent you and which has just been read by your President, but I would like to have you know that I am pleased to be here. This is the first time I have attended one of your meetings. We are so close together we should get back and forth more frequently, I think. I have had so much fun in the last twenty-four hours that I think I shall come every year.

I am grateful to you for giving me this opportunity to express my appreciation here on my feet instead of making it somewhat surreptitious. Thank you. (Applause)

President Johnsen: Thank you Dr. Barker.

We now have a very pleasant occasion in presenting to you a celebration of the tenth anniversary of the founding of the Medical-Surgical Plan. I don't know of anything that has done more good and probably created more discussion right now than the Medical-Surgical Plan.

It seems strange that while we were all fighting compulsory health insurance we were willing to turn to anything to give us an alternative to the dreary prospect of compulsory health insurance. As the threat of federalized medicine diminishes we begin to find flaws and dissatisfaction with some of our plans. But in our Medical-Surgical Plan of New Jersey we have one of the soundest of all of the voluntary health insurance plans. We have continued to operate it on a sound basis. There has never been a move made or action taken by the Medical-Surgical Plan that has not first been approved by The Medical Society of New Jersey.

I wish to give these few introductory remarks because I feel that we should be very grateful to those who have contributed so much time and effort in bringing about our Medical-Surgical Plan, and I am sure they will go on correcting defects as they arise.

But I am very happy that we have this occasion to celebrate with them their tenth anniversary. The next hour has been turned over to the Medical-Surgical Plan and they will present a few of the speakers.

Our first speaker is Dr. L. Howard Schriver of Cincinnati, president since 1946 of the Blue Shield Medical Care Plans, Incorporated, the national association of medical society-approved Blue Shield plans; and Chairman of the Blue Shield Commission, the executive body of Blue Shield Medical Care Plans, Incorporated.

In the six years that Dr. Schriver has held his present office, the number of Blue Shield Plans has grown from nine to seventy-eight. Every working day, 28,000 new subscribers are being added to the rolls of these medically approved Blue Shield Plans. Dr. Schriver gave up his planned attendance at the opening meeting of his own Ohio State Medical Association convention to be with us here today, and we are grateful and happy to have Dr. Schriver here.

It is a great pleasure for me to introduce to you Dr. Schriver. (Applause)

Dr. L. Howard Schriver: Thank you, Dr. Johnsen.

I might say that I am possibly in danger of excommunication from the Ohio State Medical Association by coming here to New Jersey rather than being at this time in Cleveland. However, I deem it a privilege to have received this invitation to address you.

I bring to you greetings from the national association and incidentally I bring you greetings from my own State Association. Best wishes for your continued progress and success in all of your work as a medical association and also all success for your Medical-Surgical Plan.

I particularly want to congratulate you because this is the tenth anniversary of the Medical-Surgical Plan of New Jersey. And I have two reasons for congratulating you. First, I might say your success, and your success is very obvious. When I first knew the Medical-Surgical Plan of New Jersey, you had barely 125,000 subscribers. Today you have upward of 750,000 subscribers and have made a very fine and healthy growth continuously.

There is a deeper reason than just the success that prompts me to congratulate you. I congratulate you on your tenth anniversary because it is indicative of the awareness of the medical profession of New Jersey, early in the history of Blue Shield, of the need for Blue Shield service to the American public for the perpetuation of professional freedom, human dignity and good medical care that is characteristic of American medicine.

Your Blue Shield Plan, like all Blue Shield Plans, is purely an instrument to implement your desires; and when I say your desires, I mean you, the profession of New Jersey; and I hope that all of you when you think of your Blue Shield Plan will think of it as your servant, carying out your commands and your desires in the way that you want them carried out.

I would like at this time to pause, however, to pay tribute to a gentleman whom I honor and revere today. It was my great pleasure to be associated in the early days in the formation of the associated medical care plans with the late Dr. Norman Scott. I worked with and knew Dr. Scott very intimately. I think as well as you, who were meeting him more often than I, I understood his character, his integrity, his courage and his definite honesty and sincerity of purpose in everything that came to his attention.

His death was a great loss to New Jersey, a great loss to the Blue Shield Association, and I wish here to pay my personal and, as well, the commission's tribute to the pioneering fine work that Dr. Scott rendered and made this movement successful.

When the Blue Shield organization was formed, it was formed because of the voice vote of the House of Delegates of the American Medical Association in December 1945. The American medical profession realized that they must do something positive and not continue with a negative program. They instructed the Board of Trustees of the American Medical Association to settle down to form some type of nonprofit health protection organization to render service to the American public as a counter-action against what was then a very serious threat of socialization and slavery of the American medical profession.

The A. M. A. Trustees delegated this to the Medical Service Council. In March 1946 they called a meeting of nine representatives of the plans, all independently working in their respective communities, to form some type of organization. As Dr. Johnsen has said to you, this has grown from nine to seventy-eight plans, covering, almost in its entirety, all of the United States including the Territories of Hawaii and Puerto Rico.

The American public have accepted and approved this, as reflected by the fact that at the time of the organization the overall, complete subscribing number in the United States was about two and one half millions of people, and today twenty-three million subscribers enjoy Blue Shield protection.

It proves that the public has definitely accepted our scheme of medical service. It proves that the vast majority of the medical profession itself has cooperated and supported it. Without that support and cooperation, of course, the movement would never have succeeded.

The impetus for the Blue Shield Plans started in 1939, gradually for a few years growing, and then growing very rapidly after 1944. They were exploring a field that had never been explored before—the pre-payment of health protection for the American public. No other organization was ever interested in this type of protection to the American people, and naturally, being the pioneers, as you in New Jersey were (as indicated by your tenth anniversary) very little was known about how to do it, about its actuarial soundness, about what type of service to render or what type of benefits to offer. But we did explore this field and now with experience and with a large number of subscribers we feel that we are on an actuarially sound basis. We can proceed from here and have always proceeded on, I might say, in extending the coverage and the benefits to the people as experience and knowledge and actuarial soundness made it possible.

There has been a tendency to the ever-increasing extension of benefits and particularly in the change-over from what was originally an indemnity program in most instances to what we call either full payment or service contracts. And here again I congratulate New Jersey because you were one of the early pioneers in offering this type of protection to the American public.

Until we offer service benefits to all people, by all plans, we will not meet the needs of the American public. I have no better authority for that statement than the stand taken by the American Medical Association charging the public of America to budget their unpredictable health costs just as they budget other necessary items. But it is impossible for them to budget their health needs unless we offer them an overall service contract.

The service contract presents many problems, I admit, but I think that, in all probability, with the co-insurance principle injected into the service contract to protect against abuse, we in the medical profession can profitably serve the American people, preserve our dignity and our freedom and the American public will accept this type of medical service. I think that your growth is a reflection of the success of the introduction of the service principle.

I want also to congratulate the Medical-Surgical Plan of New Jersey upon another accomplishment that I think is very important; that is the spirit of cooperation that you in New Jersey enjoy; cooperation between your New Jersey Blue Cross Plan and your Blue Shield Plan. Unless the Blue Cross and Blue Shield in every part of this country work harmoniously and cooperatively, we cannot reach the goal we desire.

These two organizations have basic, fundamental philosophies—service—and the one should remain sharply delineated within its respective function. The Blue Cross should never be injected into health protection as medical service, and the Blue Shield should never inject itself into the Blue Cross function of hospital protection. But there is no reason why these two organizations should not function harmoniously together. I regret very much that in a few locations in this country this harmony and cooperation do not exist, and it is harmful to both movements. It is harmful to the preservation of voluntary hospital and medical care. Fortunately, in most instances, these differences can be solved, because fortunately, in most instances, they are results of some personality differences of those who are running the show in those respective places.

I hope that no member of the New Jersey medi-

cal profession regards the Blue Shield Plan of New Jersey as an insurance company. This is not a question of insurance; this is not a question of dollars and cents; it is not a question of your or my return for our services. We have more at stake than dollars and cents; we have our own personal freedom and human dignity and the preservation of good medical care at stake, which is infinitely more important than a few dollars and what's on the left side of that contract as far as fees and benefits are concerned.

Those who work for you in your local Blue Shield Plan—and I could say this universally over this country—are only too glad to accept your guidance, to receive your desires and demands for what type of service you want them to offer to the public. It is your plan and we of the Blue Shield are purely your servants. If Blue Shield ever does anything that does not meet with the approval of you, as the medical profession, it is within your province at any time to correct those inefficiencies and things that you do not like.

The threat of socialization in medicine is just as dire a threat today as it was in 1938 when the Wagner-Murray-Dingell Bill was first proposed. It is true we are not today in danger of a blunt frontal legislative attack as we were in the late '39's and early '40's. We have a more insidious enemy than that today. They have gotten a little smarter down in Washington than they were at that time.

At that time they thought they could appeal to the emotions of the American public and put over this thing very quickly. Well, they didn't do it. The American public resisted it; the medical profession, fortunately, resisted it intelligently.

We haven't that frontal attack so apparent today. The greatest enemy to American civilization today, the greatest single person who would do more if he could, to wreck American civilization and human dignity is Mr. Oscar Ewing. They will not stop because they were unable to put over a frontal attack. They are constantly making attacks on the flank and now they are a lot of little rats eating the cheese piece by piece, introducing here and there legislative proposals that undermine the structure and the arch of freedom.

Unless we are constantly alert and unless we behave properly and unless we satisfy the needs of the American public with dignity to ourselves and freedom retained and just compensation for the services rendered which the American public are willing to pay, we shall perish.

So between you and slavery I assure you stands the prepayment voluntary health protection movement as represented by the Blue Shield Plan, and I hope that you, as you have done here in the past, will cooperate with your Blue Shield Plan. I ask for cooperation on the part of the national organization, from your own unit and your own plan, and I am sure that if we succeed in doing the things that we should do, we will preserve freedom and dignity and good medical care for the American public.

Again I congratulate you. I extend to you my full appreciation of the opportunity to be here, and I don't want to infringe upon your time any longer. Thank you very much. (Applause)

PRESIDENT JOHNSEN: Thank you Dr. Schriver, for this very splendid presentation of the Medical-Surgical Plan and its ideals.

At this time we have the pleasure of having with us the Executive Director since 1946 of the Blue Shield Medical Care Plans, Incorporated, who came to his present position from the California Physicians' Service, the California Blue Shield Plan. He will present an award to the Medical-Surgical Plan of New Jersey in commemoration of its having reached its tenth anniversary, which will be received on behalf of the Plan by Dr. Royal A. Schaaf, President of the Medical-Surgical Plan of New Jersey.

At this time I would like to have this House give a rising vote of thanks in appreciation to Dr. Schaaf, who is with us again after having been away from us for awhile due to his illness; but we are all happy to see him with us, and I think it is very appropriate for this House to stand up and give a rising vote of thanks to Dr. Schaaf.

(The members arose and applauded.)

PRESIDENT JOHNSEN: It is my pleasure now to introduce Mr. Frank E. Smith, Executive Director of Blue Shield Medical Care Plan.

MR. FRANK E. SMITH: Dr. Johnsen, Members of the House of Delegates, and Guests: My privilege in being here this morning is obviously to fulfill a function as a representative and as a symbol of a lot of other people who might have wished that they could be here this morning, not only to do this job but perhaps observe it.

I, too, would like to pay my personal tribute to the memory of Dr. Norman Scott. I have never had a job in all of my life that I have enjoyed as much as the one in which I am presently employed. I am most proud as a non-medical person to be working for the medical profession. And so I look back to the day that I was first employed by this organization and went to work in December 1946, and Dr. Scott, in his capacity as the Treasurer on the Blue Shield Commission, was the man who signed my first salary check in the job that I love most.

It is not for that reason alone, of course, that I pay tribute. I establish that as my first point of connection with a man whom I learned to love and to respect as one of the many men whom I call my bosses.

As Dr. Schriver has indicated, we were born at the request of the House of Delegates, through the A.M.A. Board of Trustees, and then with the help and assistance of the Council on Medical Service of the American Medical Association.

We have grown from nine charter plans to seventy-eight. The Medical-Surgical Plan of New Jersey was one of those nine charter plans and by virtue of that fact our early association with Dr. Scott as part of this organization and movement is concerned.

These 78 plans are now operating throughout 42 states, the Territories of Hawaii and Puerto Rico, the District of Columbia, the eight Canadian provinces. We have seven associate members operating in Canada.

Our plans are divided into eleven districts, geographically speaking, for purposes of governing the association, and annually each of these districts elects two persons to sit as members on the Blue Shield Commission.

The Commission is not to be confused with the Association. The corporate name, Blue Shield Medical Care Plans, Incorporated, is the corporate title of an Illinois non-profit association. The Commission is its governing body.

Each of these districts then elects two representatives to that Commission annually, one representative to be selected from among the board members of the plans in the district and the other from among the executives of the plans in that district.

Momentarily then it might be appropriate to indicate to you that following Dr. Scott we have had the privilege of having Dr. Irving P. Borsher as a member of that Commission, representing the executives of plans in the upper part of New York and the state of New Jersey, comprising District Number 3.

In addition to that we have made provision for eight Commissioners-at-large to be nominated by the Commission from among its own membership, to provide an opportunity for keeping on that Commission, men who have served well, who have learned the business, and whose value to the Commission is beyond measure. Seven of those eight vacancies have been filled. Dr. Paul Hawley, of the American College of Surgeons, is a member of our Commission, having been elected as a member-at-large; Dr. Schriver, our president, after having served as a representative of his district for several years, was elected a Commissioner-at-large.

Seven, then, added to the twenty-two gives us twenty-nine men on that governing body, and from there on it is a perfectly normal corporate structure with its executive committees and its various operating committees which guide and direct the activities of our office in Chicago.

We maintain our office in Chicago in conjunction with the Blue Cross Commission, being domiciled in the same quarters. We have employed in Chicago about 55 people, about 30 of which are jointly employed with the Blue Cross Commission and the remainder are employed separately by either our Commission or the Blue Cross Commission. These people provide a variety of services to our member plans.

We have a Division of Public Relations rendering both consultation and field surveys of many kinds to our member plans in the field of public relations and enrollment; a Division of Physician Relations doing the same type of thing in that field; an Actuarial and Statistical Division gathering and compiling statistics and publishing studies and surveys and statistical data which can then in turn be used by each plan for comparative purposes in studying its own progress and its own statistical results.

It then falls to my lot, as Director of this staff and as an employee of this Commission to present this Tenth Anniversary Award in behalf of Blue Shield throughout the nation and to congratulate this plan not simply because it has had a birthday but because it has done so much with the ten years that have been given to it in which to exist.

Only eight other state-sponsored plans are ten years old or more. The oldest is the California Physicians' Service, which was started in 1939, just three years before your own Medical-Surgical Plan. The Medical-Surgical Plan is in true spirit a pioneer and among the beginners of what we now know as Blue Shield, with its twenty-three million members and its seventy-eight independently operating plans.

Dr. Schaaf, if you will come to the stand here with me I will read this citation: "A Blue Shield service award presented by the Blue Shield Commission to the Medical-Surgical Plan of New Jersey in recognition of the completion of its tenth year of service to the people of New Jersey." Signed by Dr. Schriver and by myself.

Dr. Schaaf, happy birthday! Glad to have you back; and may the next ten years even be better than the ten you have just completed. (Applause)

DR. SCHAAF: Thank you, Mr. Smith.

With the permission of the presiding officer and the body of the House of Delegates, I will make what I hope will be a suitable acknowledgment when I speak a little later. (Applause)

PRESIDENT JOHNSEN: We now have the pleasure of hearing from the man who has filled the shoes of Norman Scott, whom we all loved, who devoted his life to carrying on the work of the Medical-Surgical Plan. Dr. Borsher, from a part-time man devoting eight, ten, twelve hours of his time to a part-time duty, has now taken on full time. So I imagine that means about twenty-eight or twenty-nine hours a day. How he does it, I don't know.

It is a great pleasure and a privilege to present Dr. Irving P. Borsher, Vice-President of the Medical Surgical Plan. (Applause)

DR. BORSHER: I don't intend to take too much of your time because we have the pleasure of awaiting a wonderful speaker. But this I'd like to say to you: What is the concept? The concept is the provision of the best medical care that could be made available to all.

What does the public want? The public wants the concept. The majority of the thinking public prefers to give a continuing opportunity to the medical profession to attempt to achieve the concept. What has the medical profession available to it to attempt to achieve the concept? Compulsory approach; voluntary approach.

What is the *compulsory* approach? Legislative contract practice, probably without free choice of physician and probably on a salary or capitation basis. The profession appears to have revealed in the past that it does not wish that method of approach.

Voluntary—insurance, non-insurance.

Non-insurance. The type of medical practice that we had prior to the onset of insurance for medical services, and in New Jersey and possibly and probably elsewhere there is available, at least insofar as the indigent and the medically indigent are concerned, the Medical Service Administration of New Jersey, which is non-insurance.

So we come to voluntary insurance mechanisms; and what do we have? Blue Shield, a medium of the profession with free choice of physician and fee for service. Commercial insurance, an enterprise used by the profession with free choice of physician and fee for service. And finally, the New York Health Insurance Plan, called H.I.P., which represents a small segment of the profession, without free choice of physicians and on a capitation basis.

What shall we say as a conclusion to this bare outline? The medical profession has the responsibility of making itself completely aware, on a factual basis, of the media that are available to it; to study these media and cooperate with the media so that each medium can best achieve its potential, so that finally the medical profession can decide what is the best arrangement or arrangements for the provision of its services, to attempt to achieve the concept. (Applause)

PRESIDENT JOHNSEN: Thank you Dr. Borsher.

It is now my great pleasure to present to the Medical-Surgical Plan a citation which reads as follows:

"The Medical Society of New Jersey, in convention assembled, pridefully commemorating the tenth anniversary of the foundation of the Medical-Surgical Plan of New Jersey, proclaims its profound appreciation of the services rendered to medicine and mankind by the following, who, as members of the Board of Trustees of the Medical-Surgical Plan of New Jersey have, by their unselfish efforts and high character, given it life and integrity."

And I should like to read off the names of those of our deceased confreres, and at the conclusion I ask this House to stand in a moment of silent respect to the memory of these men who labored and gave in some cases their all so that the Medical-Surgical Plan might be the success which we see it today.

Drs. Theophilus H. Boysen, 1944; William J. Carrington, 1942; Augustus S. Knight, 1942; Thomas K. Lewis, 1942; and Norman M. Scott, 1942.

Please rise and stand for a moment in respect.

(The members silently arose.)

I shall now read the names of the present members of the Board of Trustees and past members and ask your indulgence in omissions which have not been easy to correct because of an overlapping period, and we may have omitted some name. If we have, we hope you will understand that it was entirely unintentional; but I would like, as I read these names, for each man to rise so you will know who he is.

Irving P. Borsher, Lewis W. Brown, Harry N. Comando, Samuel A. Cosgrove, William F. Costello, William E. Dodd, William K. Harryman, Sigurd W. Johnsen. Well, I don't know how that got in. I did pinch hit for a period there between officers for the presidency and I tell you right now I don't think I'll go back to that Board if I have any sense, because the six months I was there I think I spent more time at the meetings of the Medical-Surgical Plan than I have at any other thing that I have been called on to take part in. But I was very happy to participate in the short period of time.

Elton W. Lance, Mr. Arthur W. Lunn, Royal A. Schaaf, Rudolph C. Schretzmann, Reuben L. Sharp, Edward W. Sprague, Mr. John S. Thompson, Thomas J. White.

"This plaque is presented before the House of Delegates at the 186th Annual Meeting of The Medical Society of New Jersey, at Atlantic City, May 19th, 1952."

In behalf of The Medical Society of New Jersey, I take great pleasure, Dr. Schaaf, in presenting this citation.

DR. SCHAAF: Thank you, Dr. Johnsen.

Dr. Johnsen, Honored Guests, Members of the House of Delegates, and Guests: It is a great privilege to speak for the Medical-Surgical Plan today.

I would like first to express our appreciation to Dr. Schriver for the time and effort which he put into coming to Atlantic City to address us. He is an exceedingly busy man, but he always responds to requests for his presence at every anniversary meeting, and any time anybody gets a half million more subscribers, Dr. Schriver is called on and he invariably responds. On behalf of the Board of the Medical-Surgical Plan, I would like to express our deep appreciation of his courtesy in coming to speak to us today. It is deeply appreciated.

We appreciate also Mr. Smith's presence and

gracious remarks which he made in presenting the certificate from the Blue Shield Commission. Mr. Smith has been an inspiring director of the national group. He has contributed a great deal to the organizational administrative setup and he is always, by his geniality and friendliness, bringing messages of encouragement and compliments to the various plans which he visits. We are fortunate to have a man as well qualified as he to head the national group.

The Plan will be delighted to keep this testimonial on its wall. It is a beautiful thing. It is embossed and illuminated and certainly it is a testimonial that anybody could be proud and grateful for.

There are a few men whom I'd like to speak of particularly. Dr. Lance was the first President of the Plan and he left the office to enter the military service. His position was taken over by Thomas K. Lewis, who was a very stimulating leader and we remember his logical and detached approach to the problems of the distribution of medical care.

I would like to speak especially about Dr. Scott because of his patience and his persistence, his honesty and his leadership in the development of the Medical-Surgical Plan of New Jersey. We miss him very much.

It has been a challenging opportunity to the members of the Board to deal with the problems of the distribution of medical care. We have made many mistakes. We have gotten a lot of brickbats and we have gotten a few compliments, but our objective is the development of the plan which will met the needs of the profession and the people of New Jersey.

We have a long way to go; a lot remains to be done. We would like the Delegates and the members of the Medical Society and particularly our participating physicians to know that we are never offended by criticism. We don't enjoy it; we are never offended by it; and we do our best to ameliorate the conditions which have generated the complaints.

There are a few things coming up before the reference committee tomorrow. We are not disturbed as individuals; we are a little concerned because of the possible disrupting effect of some of these proposals upon the relationship of the Plan to its participating physicians. Perhaps at the reference committee tomorrow we can thresh out these problems and come to an understanding.

Most of the difficulty between the participating physicians and the Plan result from lack of understanding of what the Plan is going to do; and we on our part perhaps don't always understand what the participating physician wants us to do. But we would like to leave with you the thought that it is your Plan. The Trustees of it are your servants. We have no wish except to give you a competent and well administered plan. This we think we have done to a degree.

We now have 750,000 members and we are financially sound. Our income will be approximately ten million dollars this year. We are operating at an administrative cost of about ten per cent, which is one of the lower plans in the country in that respect, and we have about 85 cents on the dollar available for the payment of benefits and about five per cent which goes into reserve.

We have an excellent administrative staff. The medical group is headed by Dr. Borsher, as you know, and he has with him Dr. Alfano and Dr. Mele.

The administrative staff is headed by Mr. Bryan, who was formerly with the The Medical Society of New Jersey. He has been invaluable to us in developing efficient administration of what has become an immensely complex and difficult administrative problem.

On behalf of the Board, Dr. Johnsen and members of the Society, I wish to express again my appreciation for this tribute which has been paid to us.

At this moment I would like to introduce Mrs. Norman Scott, the widow of Dr. Scott. Will you come forward?

(The members arose and applauded as Dr. Schaaf presented Mrs. Scott with a bouquet of red roses.)

I'd like to present Dr. Norman M. Scott, Junior. (Applause) Dr. Scott's only begotten son with whom he was well pleased.

We have a number of important and distinguished guests and I will briefly introduce them and ask them to rise and take a bow.

First, Dr. Charles Gordon Heyd of New York, Past-President of the American Medical Association, now President of the United Medical Service of New York, a very distinguished leader in the Blue Shield movement. Dr. Heyd. (Applause)

Next is Dr. Fred Elliott of New York, certainly a pioneer in Blue Shield, who in October 1938, conferred with Dr. Sprague's original committee studying the possibility of organizing a medical service plan in New Jersey; now a Vice-President of the United Medical Service of New York. Dr. Elliott. (Applause)

Former Superintendent of Presbyterian Hospital of New York City, now Vice-President of the United Medical Service, Mr. John MacCormick of New York. (Applause)

A distinguished visitor from Connecticut, Dr. William H. Horton, General Manager of the Connecticut Medical Service, which on May 15, 1952, celebrated the enrollment of its 500,000th member and the achievement of a national Blue Shield enrollment of 23,000,000. Dr. Horton. (Applause)

The distinguished Executive Secretary of the Connecticut Medical Society and Secretary of the Connecticut Medical Service, Dr. Creighton Barker, with whom is his very gracious wife, Mrs. Barker. (Applause)

From Pennsylvania, the Executive Vice-

President of the Medical Service Association of Pennsylvania, Mr. Donald T. Diller, with his wife, Mrs. Diller. (Applause)

Again from New York City we have Mr. George P. Farrell, Director of the Bureau of Medical Care Insurance of the Medical Society of the State of New York. Mr. Farrell. (Applause)

And now it is my pleasure to introduce a man who has done as much if not more than any other single individual to bring the policy of the Medical-Surgical Plan of New Jersey to the people of New Jersey—the Executive Director of the Hospital Service Plan of New Jersey, Mr. J. Albert Durgom. (Applause)

There are a few people associated with the staff of the Medical Service Administration and Medical-Surgical Plan whom I would like to present at this time to the audience.

Since the Medical Service Administration is the progenitor, so to speak, of the Medical-Surgical Plan, and since it presently has only one employee, the Executive Secretary, I would like to present, first, Mrs. Marie F. Nugent, who is the Executive Secretary of the Medical Service Administration. Mrs. Nugent. (Applause)

Then I would like next to present the oldest associate of the plan, who was with Dr. Scott from its inception, who is still with us and who is head of the staff next to Mr. Bryan and Mr. Smith—Mrs. Jennings. (Applause)

Mr. Fred Smith, who is the Assistant Administrator over here. (Applause)

Two members of the medical staff, Dr. Alfano and Dr. Mele.

Last but not least, the *piece-de-resistance*, without which the administrative force of the Medical-Surgical Plan couldn't operate—Mr. James E. Bryan. (Applause)

I will now return the meeting to Dr. Johnsen, and I thank you again on behalf of the Trustees for this exceedingly gracious testimonial which you have given to your Board. Thank you. (Applause)

DR. JOHNSEN: It's been a nice birthday party and we hope that you will all enjoy a happy and profitable convention from here on.

We will now adjourn. The next meeting of the House of Delegates will be tomorrow at twelve-thirty. I now adjourn this House of Delegates.

(The meeting was then adjourned at 12:05 p. m.)

Tuesday Afternoon Session—May 20, 1952

The meeting of the House of Delegates convened at 12:35 p. m., President Johnsen presiding.

PRESIDENT JOHNSEN: Before I have you receive the report of the Nominating Committee, I should like to take this opportunity, with the indulgence of the House, to bring to the rostrum our lost friend whom we looked for yesterday, but who subsequently appeared and without whom I don't believe it would be possible for us to conduct an Annual Meeting of The Medical Society of New Jersey. We have had the privilege of having with us this gentleman year after year, and this year it gives me great pleasure to introduce him since he has just finished a term of office as President of the Medical Society of the State of New York.

It is with a great pleasure that I have come to the platform Dr. J. Stanley Kenney.

DR. KENNEY: Dr. Johnsen, Dave Allman, Dr. Murray, all my friends in The Medical Society of New Jersey: I am grateful for the generous remarks of Dr. Johnsen. Nevertheless, I am sure you can conduct your meetings all right, but it is lots of fun to be here, and I have been here now for something like six or seven consecutive years. I hope that my good friend, Dr. Cunniffe will be here; perhaps he will still arrive. He is supposed to share this privilege with me.

It is a very great pleasure, ladies and gentlemen, to bring to you again very cordial greetings from the officers and the council of the Medical Society of the State of New York. We have just completed what I feel is a very successful convention. We had something over 6500 physician registrations at that meeting in New York. I believe that some of the resolutions and measures that were adopted at this meeting will bear fruit in the years to come. Particularly I am pleased over the achievement we accomplished by setting up a blood bank commission under the sponsorship of the Medical Society of the State of New York. I envisage great possibilities for that.

My hope would be some time that a little closer liaison, perhaps even in an unofficial way, might be effected between the officers of your Society and ours. We have so many common problems, with only a river and a

state-line between us, and I think perhaps if we could get together two or three times a year to talk over, in an informal way, maybe common problems could be solved a little more readily. We both have to face these reciprocal agreements as to licensure and other matters that are of common concern which cross state lines.

My message during the past two years since I have been traveling around the state has been taken from the theme that Dr. Judd has so frequently brought before you, and that you will hear about tonight. That is, the importance of physicians' participation in civic affairs.

There is so much that we, as doctors, with our training, our education and our prestige in our communities can do to direct the thinking of the various lay groups that get into problems which concern health. It is a professional responsibility that we participate much more actively in the civic and lay groups in our respective communities. We can guide the thinking and bring out means of doing things which will be the result of doctor-thinking and doctor-leadership and not lay ideas which come to us sometimes already preconceived; then we raise an awful howl and we want to oppose them.

So the message I bring you, outside of the appreciation of being with you and sharing in this convention, is to mull over that thought, that we as doctors truly have a great responsibility to our public today to be more civic-minded. Thank you very much.

PRESIDENT JOHNSEN: Thank you very kindly, Dr. Kenney. It is a pleasure to have you with us now as always.

Mr. Secretary, do we have a quorum present?

SECRETARY GREIFINGER: Yes, sir, we do have a quorum.

PRESIDENT JOHNSEN: The only business to be conducted at this session is receiving the Nominating Committee's report and the election of officers. I will ask Dr. Aldrich C. Crowe, Chairman of the Nominating Committee, to present his report.

DR. CROWE: I would like to thank the members of the Nominating Committee for their very fine cooperation at yesterday's meeting. I had it on authority, but not very reliable authority because it comes from Dave Allman and Mark Greifinger—it was the most harmonius meeting in 186 years.

I would like to present our report, Mr. President. Here it is:

Office	*Term*	*From*	*To*	*Nominee*
President-Elect	1 yr.	May 1952	May 1953	Henry B. Decker, M.D., Camden
First Vice-President	1 yr.	May 1952	May 1953	Elton W. Lance, M.D., Rahway
Second Vice-President	1 yr.	May 1952	May 1953	Vincent P. Butler, M.D., Jersey City
Secretary	1 yr.	May 1952	May 1953	Marcus H. Greifinger, M.D., Newark
Treasurer	1 yr.	May 1952	May 1953	Jesse McCall, M.D., Newton
Trustees:				
First District	3 yrs.	May 1952	May 1955	Royal A. Schaaf, M.D., Newark
Second District	1 yr.	May 1952	May 1953	Luke A. Mulligan, M.D., Leonia
		(to fill unexpired term of Dr. Joseph Coleman, deceased)		
Fourth District	3 yrs.	May 1952	May 1955	C. Byron Blaisdell, M.D., Asbury Park
Eleventh Trustee	3 yrs.	May 1952	May 1955	Albert B. Kump, M.D., Bridgeton
Councilors:				
Third District	3 yrs.	May 1952	May 1955	Jacob J. Mann, M.D., Perth Amboy
Fifth District	1 yr.	May 1952	May 1953	Isaac N. Patterson, M.D., Westville
		(to fill unexpired term of Dr. Chester I. Ulmer, resigned)		
A.M.A. Delegates and Alternates:				
Delegate	2 yrs.	Jan. 1953	Dec. 1954	J. Wallace Hurff, M.D., Newark
Alternate	2 yrs.	Jan. 1953	Dec. 1954	John H. Rowland, M.D., New Brunswick
Delegate	2 yrs.	Jan. 1953	Dec. 1954	Elmer P. Weigel, M.D., Plainfield
Alternate	2 yrs.	Jan. 1953	Dec. 1954	Aldrich C. Crowe, M.D., Ocean City
Delegate	2 yrs.	Jan. 1953	Dec. 1954	L. Samuel Slea, M.D., Trenton
Alternate	2 yrs.	Jan. 1953	Dec. 1954	Herschel Pettit, M.D., Ocean City
Delegates and Alternates to Other States:				
New York—Delegate	1 yr.	May 1952	May 1953	Harrold A. Murray, M.D., Newark
Alternate	1 yr.	May 1952	May 1953	William F. Costello, M.D., Dover
Connecticut—Delegate	1 yr.	May 1952	May 1953	C. Byron Blaisdell, M.D., Asbury Park
Alternate	1 yr.	May 1952	May 1953	Blackwell Sawyer, M.D., Toms River
Standing Committees:				
Finance and Budget	6 yrs.	May 1952	May 1958	Anthony J. Conty, M.D., Union City
Publication	3 yrs.	May 1952	May 1955	Joseph E. Mott, M.D., Paterson
Scientific Work:				
Fourth District	5 yrs.	May 1952	May 1957	S. Emlen Stokes, M.D., Moorestown

President Johnsen: Thank you Dr. Crowe.

Dr. Crowe: I move it be received.

Dr. Kaufman (Essex): Second the motion.

President Johnsen: Any discussion? All in favor signify by saying "Aye". So ordered. We shall then proceed to the election.

(Upon motions duly made, seconded and carried, the nominees were elected to the various offices, and the Secretary was instructed to cast a ballot for each nominee. There were no nominations from the floor.)

President Johnsen: Thank you. This is really harmonious and I hope that we will continue harmoniously from now on.

(The meeting was then adjourned at 12:55 p. m.)

Wednesday Morning Session—May 21, 1952

The meeting of the House of Delegates convened at 9:50 a. m., President Johnsen presiding.

President Johnsen: Dr. Greifinger, do we have a quorum?

Secretary Greifinger: Yes, sir, we do have a quorum.

President Johnsen: Having a quorum present, I declare this House of Delegates open.

The first report we will have is the report of Reference Committee "A". Dr. Louis S. Wegryn.

Dr. L. S. Wegryn: Here is report of Reference Committee "A":

The report of the President was studied in detail and the committee was without exception in accord with the very generous, but deserved credit he gives the members of his administration. Only by inference, however, does he refer to truly enormous amount of time, thought and energy he himself expended which have added so much to the good of The Medical Society of New Jersey.

For the Board of Trustees we approve their devotion to the Society and in particular acclaim their establishment of the Medical-Dental Liaison Committee, the Medical-Legal Liaison Committee, and the Medical-Hospital Liaison Committee.

Though the Secretary's report gives but an inkling of the volume of work his office transacts, we approve the report heartily and commend his efforts. We deplore the fact that there is a large proportion of delinquents and reiterate his suggestion that the counties emphasize the dangers delinquents incur. Not only is insurance dependent upon membership in good standing but most staff appointments as well.

We congratulate the Judicial Council on the accomplishments of the transition under the new amendment to the Constitution and upon the fact that there have been so few appeals from the judicial committees in the county societies. We concur in emphasizing the importance of understanding in advance relative to fees and the expected accomplishments of treatment.

We approve the report of the Executive Officer and we commend him for the diligence and skill with which he has conducted our affairs.

On motion made, seconded and carried, each section of this report was approved and adopted.

President Johnsen: And now, Dr. Cottone.

Dr. R. J. Cottone: Here is the report from Reference Committee "B".

The Committee considered the report of the Treasurer, the report of the Finance and Budget Committee, and the report of the Publication Committee.

All items in the report of the Treasurer were carefully scrutinized and verified. The administration of the office of Treasurer is obviously at a very competent and highly satisfactory level, and the Reference Committee recommends to the House of Delegates, a vote of appreciation to Dr. George J. Young for his efforts in the discharge of the duties of his office.

The report of the Finance and Budget Committee was also analyzed. Each item was carefully scrutinized and the budget for 1952-53 was studied. Several questions propounded by members of the Committee and visitors were satisfactorily answered and explained by Dr. Allman, Chairman of the Finance and Budget Committee. It was the general consensus that the budgetary requests are fully justified and necessary for the conduct of the work of the Society. The Committee recommends the House of Delegates approve the requested budget for 1952-53 as submitted by the Committee on Finance and Budget without change.

The Committee recommends that the assessment for 1953 be placed at $25 per capita.

The Committee was favorably impressed by the accuracy and full information placed at its disposal by Dr. Allman and Mrs. Madden and recommends to the House of Delegates that the body express its appreciation to the members of this Committee for the time and effort which they have put in the study for the preparation of the budget for the ensuing year.

The Committee considered the report of the Publication Committee and recommends to the House of Delegates that it be approved as published without modification. The Committee wishes to commend the Publication Committee and the editor

for the outstanding character of our monthly publication.

The following resolution was unanimously approved by your Reference Committee and it is recommended that it be adopted by the House of Delegates:

WHEREAS, the prevailing method of billing the membership separately for their A.M.A. membership dues through the Executive Offices of the State Society involves reduplication of efforts,

WHEREAS, the billing for county, state and A.M.A. membership dues could readily be made by county societies and the monies transmitted to the A.M.A. through the State Society,

BE IT RESOLVED, that the Board of Trustees of The Medical Society of New Jersey recommends to the House of Delegates that the county societies be directed hereafter to collect the A.M.A. dues.

A second resolution, as follows, was unanimously approved and is also recommended for adoption by the House of Delegates:

WHEREAS, for the work entailed in the collection and recording of A.M.A. membership dues, The Medical Society of New Jersey presently is compensated at the rate of one per cent (1%) of the total monies involved, and

WHEREAS, the cost to The Medical Society of New Jersey for this work approximates three and one-half to four per cent (3½-4%) of the total monies involved,

BE IT RESOLVED, that The Medical Society of New Jersey respectfully requests that the American Medical Association make an equitable upward revision of the rate of compensation for the work of dues collection or release The Medical Society of New Jersey from the obligation of further collection of dues for the national organization.

PRESIDENT JOHNSEN: Thank you Dr. Cottone.

On motion made, seconded and carried, each section of this report was approved and adopted. I now call on Dr. Kenneth E. Gardner for Reference Committee "C".

DR. GARDNER: Mr. President, Members of the House of Delegates: I'd like to make just a few preliminary remarks before presenting this report.

Reference Committee "C" was asked to consider several controversial resolutions. In order to present a comprehensive report, it held three meetings. The first was to consider the nature of the resolutions, the second and third consisted of open hearings on the resolutions; and this was followed by a committee meeting to prepare the following recommendations.

I would like to thank the many members of the Society who attended these meetings and who gave us the benefit of their opinions. I particularly thank the members of the Committee, who were: Dr. Ferdinand K. Engelhart, Dr. Benjamin F. Lee, Dr. George M. Knowles and Dr. Stanley Teskey, for their time, their cooperation and their valuable deliberation. Here is our report:

The Committee approved the annual report of Medical Service Administration and the Medical-Surgical Plan, together with the 1952 supplemental report of Medical-Surgical Plan as presented by Dr. Royal A. Schaaf, President of the Board of Trustees. The Committee would like to congratulate Medical-Surgical Plan on its annual report and on the progress of Medical-Surgical Plan during the past ten years.

The Committee approved the nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey as presented at the first session of the House of Delegates.

The Committee approved the nominations for membership on the Board of Governors of Medical Service Administration of New Jersey as presented at the first session of the House of Delegates.

A resolution concerning the designation of the Medical Director of Medical Service Administration and of Director of Medical-Surgical Plan as its Director of the Distribution of Medical Care was approved.

The Committee does *not* recommend the adoption of the resolution from the Society of Surgeons of New Jersey because no agreement exists between this group and the Medical-Surgical Plan. The Society of Surgeons is one of the twenty-one conferring groups with the Medical-Surgical Plan and functions in an advisory capacity only.

The Union County resolution (regarding an open meeting to be held annually at the House of Delegates to discuss problems of Medical-Surgical Plan) was approved as written, with the recommendation that the time and place of the meeting be at the discretion of the President.

Reference Committee "C" is in accord with the intent of the Mercer County resolution where fee-splitting is involved and where it implies payment to a referring physician who does not participate in the care of the patient. However, distribution of fees to two or more physicians who have participated in the care of the same patient seems an equitable and fair procedure. Since there is a wide variation from one county to another in the opinions and practices of physicians who are unquestionably honest, ethical, and sincere, it is the opinion of Reference Committee "C" that *no definite action be taken upon this resolution at this time*, but that opinions concerned with the difference between fee-splitting (which implies secrecy and non-participation, and a distribution of fees among participating physicians) be obtained from the American Medical Association and the American College of Surgeons, the two competent bodies which determine ethical standards and practices for the profession as a whole. These opinions are then to be referred to the Trustees of The Medical Society of New Jersey for a decision on ethical procedure.

DR. E. P. SACKS-WILNER (Mercer Coun-

ty): I think, in the future if a new member is appointed to the Board of Trustees or the Board of Governors, some consideration be given for the doctors in the southern part of the state, below New Brunswick, so that we at least have one or two representatives on this group. I would like to make a recommendation that that be included in the minutes.

PRESIDENT JOHNSEN: Thank you Doctor.

(The motion was seconded.)

Any further discussion? Are you ready for the question? All in favor signify by saying "Aye". Contrary minded. So ordered.

DR. GARDNER: There was never any attempt to exclude anyone from any part of New Jersey. The difficulty is frequently in getting men to become members of this Board, and there are still two vacancies. There probably will be a third vacancy.

If any members from the counties of Southern New Jersey care to have a man on the Board of Trustees, I am sure their names would be considered if they were referred to the proper organization.

DR. SCHAAF: Mr. President, I'd like to say, for the benefit of Dr. Sacks-Wilner, that we have discussed with Dr. Patrick J. Corrigan his willingness to become a member of the Board of the Medical-Surgical Plan. He has agreed to accept this appointment and I shall present his name in nomination to the Board at its next regular meeting. I hope that that will meet the desires of some of the southern counties.

Our problem really has been to get men who would come up from Camden or Atlantic or somewhere else. It is tedious work; it is time-consuming and very trying and some of the men we have previously had on the Board resigned because of the difficulty and the time it took in attending.

We think that Dr. Corrigan will make an excellent addition. We will be very happy to have him.

DR. GARDNER: The Mercer County resolution produced a good deal of discussion. This, you remember, concerned the partitioning of fees by the Medical-Surgical Plan to two or more doctors who joined in the care of a patient. About this, there was a very fine exchange of ideas at the open meeting. May I say that at no time were any opinions expressed which were critical of any individual, but they were expressed, rather, to try to decide what was the best ethical procedure on the payment of fees by the members or for the members of the Society when two or more physicians were providing services for the same patient at the same time.

(Dr. Gardner then reread the last paragraph of the report.)

DR. GARDNER: I move the adoption of this report, Mr. President.

(The motion was seconded.)

DR. SACKS-WILNER: I made a motion before, so I can't put this as a motion on the floor. I'd like to make an amendment to—

PRESIDENT JOHNSEN: No amendments are in order at this time.

DR. SACKS-WILNER: Can we change this report in any way?

PRESIDENT JOHNSEN: No. You can't change it. You can accept it or you can reject it. On this motion now, Doctor, we are discussing the report of the Reference Committee and no new motions are in order.

DR. SACKS-WILNER: I would like to suggest that this particular paragraph temporarily be voted down so that it might be changed to read: "Reference Committee 'C' ", and then delete "is in accord with the intent of" and replace that by "agrees in principle with the Mercer County Resolution"; and further, go down to the bottom: "that opinions . . . be obtained from the American Medical Association and the American College of Surgeons," have in addition the "American Board of Surgeons".

PRESIDENT JOHNSEN: Doctor, those suggestions will be considered by the Board of Trustees if you adopt this resolution, you can be assured of that. But at this time it is not wise to open up this report for change unless the Chairman so wishes.

A DELEGATE: If this is adopted will the Board of Trustees of the Medical-Surgical Plan hold in abeyance their proposal to carry this proposition out until the Board of Trustees has made a decision?

PRESIDENT JOHNSEN: Very definitely. No action can be taken until it is approved by the Board anyway.

Are you ready for the question? All in favor signify by saying "Aye". Contrary minded? So ordered.

DR. GARDNER: I move now that the entire report as a whole be adopted.

DR. YAGUDA: Second the motion.

PRESIDENT JOHNSEN: Any discussion? All in favor signify by saying "Aye". So ordered. I want to congratulate the House and especially this committee for the splendid way in which this Reference Committee conducted its work. All parties were given a thorough, complete and fair hearing and I am sure you are going to find that this will be resolved to the entire satisfaction of the House. Once more it illus-

trates the value of a democratic procedure where everyone can have their say, and I thank the Reference Committee for their splendid work and all of the members who contributed in the discussion.

The next committee will be Reference Committee "D". Dr. Thomas H. McGlade, Chairman.

DR. MCGLADE: Reference Committee "D" met at 11 a. m. with all members present. In addition to your chairman, they consisted of Clarence A. Bowersox, Lloyd A. Hamilton, L. Roberto Carmona, and George E. Barbour.

The following reports were read and approved:

Medical Defense and Insurance. I might say this Committee on Medical Defense and Insurance stressed the point that, due to the fact that the courts have a tendency to give large verdicts, we should all assess ourselves as to whether we feel that we have sufficient liability coverage. They also felt that we should continue with the same carriers in regard to our liability insurance and health and accident policies.

The Woman's Auxiliary. The Committee congratulated them on the splendid work they have done during the course of the year.

The Medical Education Committee has been extremely active and plans for the new medical-dental school are proceeding very satisfactorily.

In regard to the *State Board of Medical Examiners* this Board suggested, and the Reference Committee concurred, that there would be certain advantages to annual registration of the doctors in New Jersey.

Mr. President, I recommend the adoption of this report.

(The motion was seconded.)

PRESIDENT JOHNSEN: Any discussion? All in favor signify by saying "Aye". Contrary minded? So ordered.

Thank you, Dr. McGlade.

Our next report is from the Reference Committee on Constitution and By-Laws. Dr. C. Byron Blaisdell.

DR. BLAISDELL: We did not publish or include in mimeographed form the amendments because they were first submitted by the Board of Trustees; they have been approved by the counsel of the Society, they were published in THE JOURNAL. Unless there is a request to have the reading of the sections, which I will be very glad to do, I will just refer to them by title and move their adoption. Here is our report:

The Reference Committee approved the proposed amendment to Chapter I—Membership—as published in the annual reports and recommends its adoption by the House of Delegates.

The Reference Committee approved the proposed amendment to Chapter IX, Section 2—General Fund—as published in the annual reports and recommends its adoption by the House of Delegates. The Reference Committee reviewed the proposed amendment to Article 6—Board of Trustees—and approved such amendment which will be considered for vote by the House of Delegates in 1953.

Deletion of Chapter 10, Section 4, title "Appeals" was approved unanimously.

Amendment to Chapter VIII, Section 2—delete "Committee on Scientific Work", approved;

Chapter VIII, Section 6—delete complete section —title "Committee on Scientific Work"—approved;

Amendment to Chapter X, Section 7—delete "and the Secretary of the Committee on Scientific Work" approved.

The recommendations and report, on motion made and called, were approved.

PRESIDENT JOHNSEN: Thank you. Now we hear from Dr. Jehl.

DR. JOSEPH R. JEHL: Here is the report of your Reference Committee on Miscellaneous Business:

The report on Scientific Program was considered. The recommendations in Section 1, namely: "Section programs should be planned for the interest of the general membership of the Society", was approved.

Section 2—"The sections on General Medicine, General Surgery, and General Practice will meet yearly", was approved.

Section 3—"The remaining sixteen sections will meet on alternate years", was disapproved. It was the feeling of the Committee (after discussion with members of the Sections) that this should be referred to the Trustees for better solution and planning. The Sections on Obstetrics, Pediatrics, and Eye, Ear, Nose and Throat were considered of sufficient general interest to warrant annual meetings.

The report of the Committee on Scientific Exhibit was approved.

The recommendation of the Union County Medical Society regarding M.D. license plates was approved as amended.

DR. F. C. BOWERS (Morris): About the M.D. license plates, we believe that the intent of this resolution is a good one; however, the wording will make it impractical if not impossible of enforcement. We suggest the change be that the plates would be issued only to physicians who have the Degree of Doctor of Medicine acceptable to the New Jersey State Board of Medical Examiners.

PRESIDENT JOHNSEN: Doctor, could I explain just a few words? Maybe that will clarify what we can do and what we can't do about this resolution.

The fact that the Motor Vehicle Commissioner was issuing license plates to others than

physicians was brought to my attention about two weeks before the plates were going to be issued. We immediately communicated with the Commissioner and asked why he had taken this action without consulting us. We were advised by our attorney that the Commissioner of Motor Vehicles had it within his power to give these plates to whomever he wished, by a ruling of his Department.

When we discussed the matter with the former Commissioner of Motor Vehicles, a year ago, we specifically stated that if these plates were issued to any other than doctors of medicine, we didn't want the plates and at that time it was agreed by the former Commissioner that this would be done.

Now, this resolution is, in any event, an advisory resolution. You can be assured that both the Board of Trustees and the President did everything in their power to prevent this state of affairs. But we received a ruling from our own attorney that the plates were issued in accordance with the directions of the Commissioner of Motor Vehicles and we are now entering into negotiations with him to see what can be done to see that this thing is remedied and some action will have to be proposed by the Board of Trustees in any event.

I hope with those explanatory remarks you may be satisfied to leave the resolution as it is.

Dr. Bowers: It's only that we want it clarified, so that we won't make the same mistake again, by recommending that these plates be issued only to those people who we think are the proper people to have them; that's the only reason.

President Johnsen: Is that agreeable, Mr. Chairman?

Dr. Jehl: The Committee considered the question of the wording of the resolution and although we felt that there were some words which were used inadvisedly—in other words, there were certain terms which were rather indefinite and loose—we felt that it would be better to let the resolution stand as it is than to make any great change in it, which actually we couldn't do—we could only consider the resolution in hand—and it was our intent that it would be referred to the Board of Trustees and from there it would probably meet with a happy solution.

President Johnsen: Is that amendment agreeable?

Dr. Jehl: Yes.

President Johnsen: We will vote on the amendment then. The amendment to this has been proposed. Will you state those changes, please?

Dr. Bowers: The Director of Motor Vehicles of New Jersey be authorized to issue such distinctive plates only to physicians who have the degree of Doctor of Medicine acceptable to the New Jersey State Board of Medical Examiners.

President Johnsen: Thank you, Doctor. You have heard the amendment. Is that seconded?

(The motion was seconded.)

Any further discussion? All in favor of the amendment signify by saying "Aye". So ordered.

Now the original resolution as amended. Is that seconded?

Dr. Yaguda: Second the motion.

President Johnsen: Any further discussion? All in favor signify by saying "Aye". Contrary? So ordered.

Dr. Jehl: The recommendation of the Board of Trustees that the 187th Annual Meeting be held at Haddon Hall, Atlantic City, on May 18-21, 1953, was approved.

President Johnsen: Dr. Allman says he will second that. Any discussion? All in favor signify by saying "Aye". So ordered.

Dr. Jehl: Mr. Chairman I move the adoption of the report of the Committee on Miscellaneous Business.

(The motion was seconded.)

President Johnsen: Any discussion? All in favor signify by saying "Aye". Contrary minded? So ordered.

Thank you very much, Dr. Jehl. Dr. Driscoll is unable to be with us, so Dr. Maurice Chesler will read the report of Reference Committee "E".

Dr. M. Chesler: Here is the report of Reference Committee "E".

Reports of the Welfare Committee, the Subcommittees of the Welfare Committee, the Advisory Committees to the Subcommittees of the Welfare Committee, and the Special Committee on the Medical School of the Welfare Committee were read and *approved.*

The Committee *disapproved* the resolution from Gloucester County requesting the employment of a full-time medical lobbyist in Trenton. This action was taken because arrangements have already been made to secure legal assistance in analyzing bills before the Legislature.

The Committee *approved* a resolution from the New Jersey Society of Clinical Pathologists requesting the Council on Medical Education and Hospitals to limit its approval of Specialty Boards.

The Committee *approved* a resolution from Salem County on the restriction of surgical privileges of the general practitioner.

A resolution from Union County that Government medical care be strictly limited to service connected medical disabilities of the veteran was *approved.*

The Committee *approved* a resolution from Union County establishing a minimum fee basis for compensation cases.

On motion made, seconded and carried, each section of this report was approved and adopted. The Chair then called on Dr. R. C. Schretzmann to read the report of the Reference Committee on Resolutions and Memorials.

DR. R. C. SCHRETZMANN: Here is the report of our Reference Committee:

The resolution on fluoridation of public water supplies, as approved by the Board of Trustees, was unanimously approved by the Committee and is referred to the House of Delegates for action.

The following nominations for emeritus membership were uanimously approved by the Committee and are referred to the House of Delegates for action:

Atlantic County—Dr. C. Coulter Charlton
Bergen County—Dr. David Corn
Dr. George M. Levitas
Camden County—Dr. Ernest W. Clark
Essex County—Dr. Chester R. Brown
Dr. Charles V. Craster
Dr. James J. Edelen
Dr. Harry B. Epstein
Dr. Julius Levy
Dr. Browne Morgan
Dr. William Petry
Dr. Frederick G. Shaul
Dr. Harold A. Tarbell
Hudson County—Dr. Charles H. Finke
Dr. George W. Muttart
Dr. Alfred A. Mutter
Mercer County—Dr. John H. McCullough
Middlesex County—Dr. John F. Anderson
Dr. Chester T. Brown
Dr. Charles I. Silk
Ocean County—Dr. Frank Lehmacher
Somerset County—Dr. Lancelot Ely
Dr. Frank L. Field
Union County—Dr. Fred W. Sell
Dr. Charles B. Lufburrow
Dr. Grace Holmes
Dr. Ida H. Frohwein

On motion, this report was approved and adopted by the House of Delegates.

PRESIDENT JOHNSEN: Thank you Dr. Schretzmann.

I would like unanimous consent of the House of Delegates to present a resolution which was omitted from the first one—a resolution pertaining to Dr. Young.

(Consent being unanimously given, the following resolution was read by the president.)

After thirteen years of superlative service, Dr. George J. Young is, as of this time, relinquishing his post as Treasurer of The Medical Society of New Jersey. With genuine regret we defer to his wishes to be relieved of the exactions of his office, and with the most profound appreciation of all that he has given to the Society across the many years.

Dr. Young has not only been our Treasurer in the sense that he has been the faithful custodian of the exchequer, but in his person and actions he has been constantly the repository and exemplification of all the representative qualities of gentleman and doctor of medicine.

For the wealth that he has guarded for us, and for the even greater wealth of inspiration and fellowship that he has given to us, we thank him from our hearts.

PRESIDENT JOHNSEN: I move you gentlemen, a rising vote of thanks in honor of a good member, a good treasurer, a good man: Dr. George J. Young.

(The members arose and applauded.)

DR. WEIGEL: Mr. President, I move at this time the reconsideration of the first resolution in reference Committee "B" because I do not believe it adequately expresses the opinion of the Reference Committee at that time.

DR. SCHAAF: I second the motion.

PRESIDENT JOHNSEN: You have heard the motion to reconsider the report of Reference Committee "B", which has been duly moved and seconded, that portion pertaining to that resolution. All in favor signify by saying "Aye". Contrary minded. (There were several Noes.)

A DELEGATE: What is the resolution?

PRESIDENT JOHNSEN: In view of the fact that there is some confusion regarding this resolution and in view of the fact that there is a misunderstanding on the part of the House as to what is involved in it, I would feel that we should require unanimous consent to open up the reconsideration of this at this time; and if it is agreeable to Dr. Weigel I would say that we shall follow his request in clarifying the matter when the matter comes up to the Board of Trustees, if that is satisfactory.

DR. WEIGEL: Mr. Chairman, this is the one referring to collection of dues for the A.M.A. It is the first resolution in Reference Committee "B's" report that was adopted.

PRESIDENT JOHNSEN: The resolution, gentlemen, is as follows:

"WHEREAS, the prevailing method of billing the membership separately for their A.M.A. membership dues through the Executive Offices of the State Society involves reduplication of efforts,

"WHEREAS, the billing for county, state and A.M.A. membership dues could readily be made by county societies and the monies transmitted to the A.M.A. through the State Society,

"BE IT RESOLVED, that the Board of Trustees of The Medical Society of New Jersey recommends

to the House of Delegates that the county societies be directed hereafter to collect the A.M.A. dues."

That is the resolution which you approved in the report of Reference Committee "B". Do you wish to reconsider this resolution?

All in favor of reconsidering this resolution signify by raising your right hand. (A number of hands were raised.)

All opposed to reconsidering. (A number of hands were raised.)

President Johnsen: The motion is lost.

Is there any unfinished business? Hearing of no unfinished business to be brought before this House, it is now my great pleasure to introduce Dr. Francis C. Weber, who will present to us our new President for the coming year. Dr. Weber.

Dr. Weber: Mr. President, Members of the House of Delegates, Ladies and Gentlemen: One hundred eighty-five years ago Essex County had the pleasure of seeing one of its members elected as the second President of The Medical Society of New Jersey. Since then we have been honored by election to that high office of twenty-two more men; ten since the turn of the century. Included amongst these latter were such men of distinction as Edward J. Ill, Wells P. Eagleton, John F. Hagerty, Francis R. Haussling, E. Zeh Hawkes and Royal A. Schaaf.

Now as Number twenty-three from Essex and Number one hundred sixty on the State roster, it is the proud privilege of Essex County to present another man of exceptional talent and ability in the person of Harrold A. Murray, a man with sparkling personality, a man with inexhaustible stamina for service, a veritable human dynamo for work.

Dr. Murray served as President of the Essex County Medical Society from May 1947, to May 1948. At the end of his term the editor of the County *Bulletin* had this to say:

"Rarely have the Essex County Medical Society had as good a President as our Harrold. He directed us with pep, vim and vigor. He represented us graciously at many professional and social meetings. He was always eager and willing to do more than his duty for organized medicine."

His life reads like a success story. He is blessed with a very charming wife. He has six children and two grandchildren.

He is attending pediatrician at St. Michael's, St. James and City Hospitals, all in Newark. He is consulting pediatrician at eight other hospitals. For four years he taught pediatrics at Columbia.

Nationally, he has been honored as an eminent physician, being a Fellow of the American College of Physicians, a Diplomate of the American Board of Pediatrics, and his most prized honor, a member of the Executive Board of the American Academy of Pediatrics.

Dr. Murray is also active in civic affairs. He is a member of the boards of the American Red Cross, the New Jersey Welfare Council and the Newark Welfare Federation. He is Vice-President of the Essex County Tuberculosis League and a member of the Governor's Committee on Youth.

In the affairs of The Medical Society of New Jersey, he has been most active. As an officer of the Society he served as Chairman of the Child Care Committee and as Chairman of the Public Health Committee. Previous to that he served for ten years as Chairman of the Annual Meeting Committee, contributing much to make these conventions the success that they are.

Because of his experience, sincerity and enthusiasm, under his leadership the welfare of The Medical Society of New Jersey is assured.

It is my happy privilege to present the incoming President, the pride of Essex County, Harrold Murray.

(The members arose and applauded.)

President-Elect Murray: Sounds like an ad for Lydia Pinkham, doesn't it?

You know, I'm going to let you in on a little secret. When I finished internship, my first year at practice I was physician for a ball team—it happened to be the Newark "Bears"—and in that year they won the pennant. They had a dynamic manager, and I think he did more for me than anybody else that I have ever met.

Now, I hope to be in a way your manager this year. We have our battery here—pretty old-looking, but, they can certainly play. They are warming up now. And each one of you is going to be a member of this well-organized team. Nobody can do this job alone. We have a terrific program, and I know that you know that now after hearing Senator Cain and Representative Judd. We are all going to help each other. We are all going to work together, and we are all trying to do a good job.

I have two very pleasant announcements. The first is the introduction of Dr. Butler. I don't know whether this is good for the Society or not. I think it is wonderful. Dr. Vincent Butler has been elected, without any contest, which is most unusual, as our Second Vice-President.

Vincent, stand up. (Applause)

We have a new Treasurer, Dr. Jesse McCall. As you know, Dr. McCall had been Trustee before he left for the Army.

You know, Dr. McCall, in every organization that I am connected with, has never let me know how much money is in the budget. I hope he will do that here, because I can spend it quicker than anybody else.

1952 SCIENTIFIC EXHIBIT AWARDS

CLASS I—For meritorious individual investigation.

1st Prize—Congenital Anterior Chest Wall Deformities of Diaphragmatic Origin—A New Interpretation

Henry A. Brodkin, M.D., Newark, N. J.

2nd Prize—Etiology of Varicose Veins

Sherman A. Eger, M.D., and Frederick B. Wagner, Jr., M.D., Jefferson Medical College and Hospital, Philadelphia, Pa.

3rd Prize—Two Million Volt X-rays in the Treatment of Cancer

Milton Friedman, M.D., Hospital for Joint Diseases, New York, N. Y.

Honorable Mention — Prevention of Esophageal Stricture by Cortisone

Norman Rosenberg, M.D., Philip J. Kunderman, M.D., Sylvan E. Moolten, M.D., and Leo Vroman, Laboratories of St. Peter's General Hospital, New Brunswick, N. J.

CLASS II—For meritorious excellence of presentation

1st Prize—The Cervix

Edwin H. Albano, M.D., and C. Joseph Ferri, M.D., Columbus Hospital, Newark, N. J.

2nd Prize—Miliary and Meningeal Tuberculosis: Therapy and Results

Samuel Cohen, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City, N. J.

3rd Prize—Juvenile Endocrinopathies

Rita S. Finkler, M.D., George M. Cohn, M.D., and Sylvia F. Becker, M.D., Beth Israel Hospital, Newark, N. J.

Honorable Mention—D-V-A Ballistocardiograph

Sidney R. Arbeit, M.D., Medical Center, Jersey City, N. J.

Upon motion made, seconded and passed, the House adjourned *sine die* at 11 a. m.

SUPPLEMENTAL ANNUAL COMMITTEE REPORTS

Reports of most of the committees were published in the May JOURNAL beginning on page 185. Certain reports were received too late for that issue. Other committees found it advisable to add supplemental reports. These are presented below.

VENEREAL DISEASE CONTROL

Robert L. McKiernan, M.D., Chairman, New Brunswick

The Committee on Venereal Disease Control deplores the growing delusion of the effect that venereal diseases are under control and are of no further importance. This is untrue. As one step to develop further interest in this, one county committee sent letters to all public officials in that county which has a high venereal disease rate. These letters urged the formation of local community committees for the purpose of preventing the spread of venereal disease and prostitution, and offered practical suggestions for such a program.

SUPPLEMENTARY REPORT OF THE SUBCOMMITTEE ON LEGISLATION

C. Byron Blaisdell, M.D., Chairman, Asbury Park

At the national level there were 232 bills of professional interest to the American Medical Association and the State Society. The persistent trend of the government to forward the socialization of medicine was definitely in evidence. Dr. Joseph Lawrence, of the American Medical Association's Washington Bureau, labeled 117 of these as "fringe" bills, designed to include woven-in government-controlled medical services, invading public health, schools, and veterans' legislation. This Committee was kept well informed of the American Medical Association's position and also given an opportunity to combat, if necessary, such legislation. In no instance, however, did we find ourselves in disagreement with the American Medical Association sufficiently to argue the point and, for the sake of a solid front, we have followed its lead.

At the state level the society membership has been informed of bills approved and disapproved through the *Membership News Letter*

which, in addition to stating our position, also gave a brief explanation of the bills and the reasons for our support or opposition. No bill was submitted by the psychologists, primarily because of the continuing lack of agreement between them and the psychiatrists. The chiropodists again desired our approval of a bill extending their privileges in setting fractures and operating on the foot but, in conjunction with our orthopedists, we felt that our position should not be changed from the opposition expressed last year. The bill accordingly was not introduced. A conference was held with representatives of the State Nursing Association at one of the numerous meetings held by your Committee, and a bill which the nurses planned to submit was discussed. Dr. Andrew Ruoff, Chairman of the Committee on Nursing, was also invited to attend and, apparently as a result of this meeting, the bill was withheld.

The passing of the Legislature of S-139, the Chiropractic Bill, came as a shocking disappointment to us all. A report on this by a special committee created by President Johnsen will explain more fully the activities in opposing the bill, both before its strength became apparent and in the last few days preceding its passage. It was evident that we had not developed support on the floor of either the Senate or Assembly to voice our opposition. Several legislators spoke in behalf of the bill and we were definitely not put in a favorable position by their remarks. The bill passed by one vote and on the 10th rollcall. A special committee, consisting of Drs. Johnsen, Murray, and Blaisdell, subsequently met with the Governor in an hour's conference and gave him our reasons for opposing the bill and desiring his veto. At present writing his decision has not been made.

As a result of this experience, it would seem desirable to re-examine and revise our methods of screening and working for or against legislation. More effective organization of county committees, to work with county representatives in the Legislature, seems definitely indicated. The need of this Committee for a special legal advisor to sift and interpret legislation and keep us currently informed is very apparent. With such an advisor working in close cooperation with the Executive Secretary of the Committee, information could then be quickly disseminated to the various county committees for action. It was evident, from comments of many persons high in the State Government, that our methods this year for influencing legislation were not looked upon with favor. It will be the aim of the coming year's Committee to perfect the handling of legislation. The Executive Secretary might well be of much greater value if he were allowed to work, with office space in the Society's Headquarters, and leave the leg work to key men and the county committees.

The Chairman wishes to thank members of the Committee and Dr. Londrigan for their cooperation and close attention to the year's program, and for the support which many other members of the Society gave the Committee on numerous occasions throughout the year.

ANNUAL REPORT OF THE TREASURER

George J. Young, M.D., Morristown

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1951-52

June 1, 1951—May 14, 1952

RECEIPTS

Cash on Hand, June 1, 1951		$209,323.25
Assessments Received:		
Atlantic County	$ 3,500.00	
Bergen County	10,625.00	
Burlington County	1,850.00	
Camden County	6,875.00	
Cape May County	950.00	
Cumberland County	1,925.00	
Essex County	34,512.50	
Gloucester County	1,500.00	
Hudson County	14,900.00	
Hunterdon County	850.00	
Mercer County	7,543.75	
Middlesex County	5,668.75	
Monmouth County	5,025.00	
Morris County	4,337.50	
Ocean County	1,025.00	
Passaic County	12,125.00	
Salem County	900.00	
Somerset County	1,725.00	
Sussex County	775.00	
Union County	12,181.25	
Warren County	850.00	
		129,643.75
A.M.A. Dues, 1950		1,620.00
A.M.A. Dues, 1951		22,255.50
A.M.A. Dues, 1952		90,070.00
Journal Advertising (net)		26,179.81
Commercial Exhibits		11,773.50
Interest		168.75
Sale of Maternal Welfare Books		665.00
Rents		715.00
Payroll Taxes Withheld		823.49

Refund of 1951-52 Budget Expenditures	800.34
1950 Assessment	25.00
A.M.A. Dues Collection	1,775.03
Permanent Capital Fund	35.77
Refund of 1950-51 Budget Expenditures	1,342.59
1952 Official List	6.00
TOTAL RECEIPTS	$497,222.78

DISBURSEMENTS

BUDGET ACCOUNTS:	
A- 1—Executive Salaries	$ 30,445.92
A- 2—Executive Office Salaries	16,613.20
A- 3—Executive Office Expenses	1,612.18
A- 4—Executive Travel	1,705.69
A- 5—House Maintenance	7,185.61
A- 6—Treasurer	71.86
A- 7—Finance and Budget Committee	54.19
A- 9—Audit	375.00
A-10—Secretary	1,351.88
A-11a–U. C. C. Tax	224.98
A-11e–Social Security Tax	540.59
A-11g–Excise Tax	112.58
A-12—Insurance	1,181.46
B- 1—Journal Publication	5,000.00
B- 5—Journal Office Expenses	311.55
C- 2—Welfare Committee	827.98
C- 2a–Medical School Committee	116.83
C- 3—Legislative Committee	1,508.77
C- 4—Public Health Committee	624.47
C- 5—Public Relations Committee	3,306.42
C- 6—Medical Practice Committee	362.49
D- 1—President	2,890.24
D- 2—A.M.A. Delegates	5,935.81
D- 8—Woman's Auxiliary	2,840.24
D-13—Medical Education	.36
D-16—Membership News Letter	2,099.87
D-19—Civil Medical Defense Com.	.69
E- 1—Board of Trustees	1,251.58
E- 2—Contingent	2,003.20
E- 4—Judicial Council	140.91
F- —Legal	1,757.73
	$ 92,545.31
Accounts Payable, May 31, 1951	8,502.32
Annual Meeting	2,013.91
Journal Publication	20,719.30
Commissions	3,683.17
Accounts Receivable	161.92
A.M.A. Dues—1950	1,620.00
A.M.A. Dues—1951	22,205.50
A.M.A. Dues—1952	87,045.00
A.M.A. Dues Collection	616.43
Assessments Refunded—1951-52	206.25
Assessments Refunded—1952-53	225.00
Permanent Home Account	4,083.99
Budget Expenses—1950-51	734.59
Janitorial Services	165.00
TOTAL DISBURSEMENTS	$244,527.69
Cash Balance, May 14, 1952	252,695.09
	$497,222.78

PERMANENT CAPITAL FUND

Cash	$ 3,565.25	
Investments	11,500.00	
Balance, May 14, 1952		$ 15,065.25

ANNUAL MEETING RESERVE

Balance, June 1, 1951	$ 6,144.03	
Receipts	11,810.71	
		$ 17,954.74
Disbursements		2,013.91
Balance, May 14, 1952		$ 15,940.83

HOUSE COMMITTEE RESERVE

Balance, June 1, 1951	$20,888.91	
Receipts	715.00	
		$ 21,603.91
Disbursements		4,083.99
Balance, May 14, 1952		$ 17,519.92

RECOMMENDED BUDGET FOR 1952-53

A- 1—Executive Salaries	$ 34,190.00
A- 2—Executive Office Salaries	21,787.00
A- 3—Executive Office Expenses	2,400.00
A- 4—Executive Office Travel	2,025.00
A- 5—House Maintenance	7,523.00
A- 6—Treasurer	350.00
A- 7—Finance and Budget Committee	250.00
A- 9—Audit	450.00
A-10—Secretary	3,000.00
A-11—Salary Taxes	1,165.00
A-12—Insurance	1,288.00
B- 1—Journal Publication	5,000.00
B- 5—Journal Office Expenses	500.00
B- 6—Journal Office Travel	100.00
C- 2—Welfare Committee	750.00
C- 3—Legislative Committee	4,000.00
C- 4—Public Health Committee	1,000.00
C- 5—Public Relations Committee	9,500.00
C- 6—Medical Practice Committee	1,000.00
C- 7—Medical School Committee	500.00
D- 1—President	3,000.00
D- 2—A.M.A. Delegates	4,150.00
D- 8—Woman's Auxiliary	5,550.00
D-13—Medical Education Committee	100.00
D-20—Medical-Dental Liaison Com.	500.00
D-21—Medical-Hospital Liaison Com.	500.00
D-22—Medical-Legal Liaison Com.	500.00
D-23—Medical Directory and Physicians Placement Service	12,000.00

E- 1—Board of Trustees	1,000.00	TOTAL RECOMMENDED BUDGET FOR 1952-53	$132,678.00
E- 2—Contingent	5,000.00		
E- 4—Judicial Council	500.00		
F- —Legal	3,100.00	RECOMMENDED PER CAPITA ASSESSMENT FOR 1953	$25.00

1952 SUPPLEMENTAL REPORT MEDICAL-SURGICAL PLAN OF NEW JERSEY

Royal A. Schaaf, M.D., President, Board of Trustees

On March 15, 1952, Medical-Surgical Plan of New Jersey distributed to each Participating Physician a copy of the Plan's "Manual for Participating Physicians".

Since that time, a number of inquiries have been made of the Plan by various physicians and professional groups, relating to the policies and operations of Medical-Surgical Plan. The Board of Trustees of the Plan takes this opportunity to offer information that will enable every physician not only to understand the purposes and procedures of the Plan, but also to participate sympathetically and with understanding in its successful operation.

The following are some of the more important questions that have been raised by one or more of our colleagues:

(1) How was the revised Schedule of Payments formulated? By whom, and for what purpose?

(2) Why does not the new Schedule provide payment on a "package-fee" basis for treatment of certain medical conditions, in the same manner as most surgical procedures are paid for?

(3) What does the Plan contemplate doing, if anything, about making provision for payment of a part of the maximum payment in a surgical case to a physician other than the operating surgeon, who participates in a surgical case by assisting at operation and/or providing pre- and/or postoperative care, or all three?

(4) Would it be preferable for the Plan to abandon the "service benefit" program and engage in a program of indemnity insurance?

We shall take up these questions in the order above stated:

(1) *Development of Present Schedule of Payments:* From May 1950, until the revised Schedule was issued, the Plan engaged in a series of conferences with representatives of various professional associations in New Jersey,* in a cooperative effort to evolve a revised Schedule of Plan Payments, under the current Subscription Contract, that would result in the most equitable distribution possible at this time among the allowances provided for the various types of procedures and services.

Sixty members of twenty-one specialty and other professional societies took part in this effort. They sought to recommend what they considered to be a fair average remuneration to a Participating Physician for services rendered a person in the income class of $5,000.00 or less, and to develop a Schedule of Payments of more appropriate fee relationship for the various procedures.

The Schedule published on March 15, 1952, represents the recommendations of the profession itself, taking into account the limitations of the Plan's resources, and the need for achieving a balance between the various categories of professional services, in harmony with the customs and conditions obtaining in medical practice throughout New Jersey.

The Plan recognizes that this Schedule of Payments is not perfect. Some surgical payments have been reduced; certain others have been increased. The average payment for anesthesia service has been increased. Similarly, payments for medical services in hospital have been increased and a new provision has been introduced to remunerate the attending physician for necessary prolonged or intensive services during a 24 to 48 hour period rendered acutely ill medical patients.

The new Schedule of Payments also provides for an increase from 60 per cent to 100 per cent in the previously limited payment for non-group maternity cases.

Since publication of the new Schedule, the Plan has received a number of communications from physicians relating to what they consider to be inconsistencies in the payments provided. These suggestions are being collated for conference with the appropriate representative groups.

(2) *Medical Services on a "Package-Fee" Basis:* Medical-Surgical Plan seeks to reflect

* Refer to list in Annual Report.

current medical practice within the limitations of its current contract provisions and premium rate.

During the conferences with representatives of the various associations of medical specialists and internists which preceded the adoption of the revised Schedule of Benefits, a prolonged study was made of the practicability of establishing a schedule of "package fees" for the treatment (within the 21 day limit of the Subscription Contract) of certain medical conditions.

This proposal was finally considered impracticable at the present time, and it was the consensus that the provision for payment for medical services appearing in the revised Schedule represents the best forward step feasible at this stage.

(3) *Payment to a Physician, Other than the Operating Surgeon, Who Participates in the Care of a Surgical Patient:* During the past several years, the Plan has received numerous inquiries by telephone and by letter from practicing physicians — both specialists and general practitioners—relative to the desirability of some procedure being developed by the Plan whereby the professional services of other physicians than the operating surgeon in a surgical case might be suitably and ethically remunerated.

Shortly before his death, the late Dr. Norman M. Scott wrote a letter to Dr. Paul R. Hawley, Director of the American College of Surgeons, under date of March 14, 1950, inquiring as to the attitude of the American College of Surgeons toward the development of some procedure to meet the problem presented to the Plan by various physicians prior to that date.

The following letter was received from Dr. Hawley under date of March 17, 1950, and was presented to the Executive Committee of the Board of Trustees of Medical-Surgical Plan on April 11, 1950:

"Replying to your letter of 14 March, the American College of Surgeons is unalterably opposed to fee splitting in any form.

"However, the position of the College is that, when the patient, (and, I suppose this can be extended to a Blue Shield Plan) is made fully aware of where his money is going, such procedure does not constitute the splitting of fees. In a recent case, one of the Judiciary Committees of the College held that, when the bill of the operating surgeon included an itemized statement of that part of the total fee which was going to the assistant in the operation (who was the physician referring the patient to the surgeon) this was not fee splitting.

"The College recognizes that in small hospitals there may be no interns or residents and the surgeon must employ an assistant. So long as the assistant actually performs a service and so long as this employment is open and above board, no injustice is done the patient.

"As regards the proper place to direct such a request as yours, the College does have local Judiciary Committees; however, their responsibilities are limited to the determination of fact and no action is recommended. Disciplinary power is vested solely in the Board of Regents of the College who also fix policies in such matters."

In April 1951, the Medical Director of Medical-Surgical Plan personally presented to Dr. Hawley a further communication requesting the comment of Dr. Hawley "in order to determine the ruling of the American College of Surgeons" in reference to a specific proposal essentially comparable to the resolution ultimately adopted by the Board of Trustees of Medical-Surgical Plan.

In his reply on May 21, 1951, Dr. Hawley stated:

"The proposal you present for the division of surgical fees by the Medical-Surgical Plan of New Jersey is satisfactory to this College, provided there is no fixed pattern for payment of any particular percentage of fees.

"This College recognizes the contributions of others than the operating surgeon to the care of surgical patients, and the fact that such must be compensated. However, the College believes that compensation should be fixed in accordance with the contribution and not be a percentage arrangement.

"It may be administratively impossible to determine the proper division of the fee in each individual case. However, a Schedule for the division can be drawn up which will fit the average case in each category. Massachusetts Medical Service has such a schedule."

On October 30, 1951, a letter was directed to the Plan by the Sussex County Medical Society formally requesting the Plan to consider this problem.

On January 3, 1952, at the conference of the "Permanent Committee on Medical-Surgical Plan" of The Medical Society of New Jersey, agreement was reached on the necessity of providing some solution to this problem and a proposal was submitted to the State Medical Society. This matter was laid on the table by the Board of Trustees of The Medical Society of New Jersey at its meeting January 6, 1952, pending further clarification by the Plan. On January 22 the Board of Trustees of the Plan adopted a resolution, with the explicit "understanding that a report of this action is to be presented to the Board of Trus-

tees of The Medical Society of New Jersey." In accordance with this direction, text of the Plan's resolution was transmitted to the Board of Trustees of The Medical Society of New Jersey and was considered by the Executive Committee of that body at a meeting on February 3, 1952. The Medical Director of the Plan, in his letter transmitting the Plan's resolution to the President of The Medical Society of New Jersey under date of January 31, 1952, stated that "the Plan will greatly appreciate the opinion or advice of the Society in respect to this proposal". The following is text of this resolution:

"WHEREAS members of the medical profession of New Jersey have requested Medical-Surgical Plan of New Jersey to consider a method whereby each eligible physician who participates in the care of a surgical case may receive payment for such care, and

"WHEREAS the American College of Surgeons 'recognizes the contributions of others than the operating surgeon to the care of surgical patients, and the fact that such must be compensated, provided there is no fixed pattern for payment of any particular percentage of fees, and that compensation should be fixed in accordance with the contribution,' and

"WHEREAS a division of the surgical payment is acceptable to the Plan provided that there is no increase in the cost of the surgical case, and further provided that the principle of division of such payment is acceptable to the medical profession of New Jersey, therefore be it

"RESOLVED that, with respect to services rendered on and after a date to be specified by the Executive Committee, and with the written advice and consent of the operating surgeon as to the physicians who rendered the services and the respective amounts payable to them, and with notification to the subscriber of the payments made, in cases in which the scheduled maximum Plan payment for the surgical procedure is $100 or more, the Plan may, subject to the conditions hereinabove stated, pay a part of the scheduled maximum surgical payment to each eligible physician (other than the operating surgeon) who participates in the care of the patient, by rendering pre- and/or post-operative care and/or assistance at operation according to the following formula:

"For surgical procedures for which the maximum scheduled Plan payment is $100 to $149—Up to $25

"For surgical procedures for which the maximum scheduled Plan payment is $150 to $199—Up to $35

"For surgical procedures for which the maximum scheduled Plan payment is $200 to $250—Up to $50"

Under date of February 4, 1952, the Chairman of the Executive Committee of the Board of Trustees of The Medical Society of New Jersey informed the Medical Director of the Plan that "in view of the action of the Board of Trustees on January 6 tabling this matter, no action could be taken by the Executive Committee. However, the Executive Committee suggests that you circularize the Participating Physicians of the Medical-Surgical Plan to obtain a vote on the proposal contained in your resolution".

In view of the fact that conferences had already been arranged to take place between January 30 and February 20, 1952, with the County Society Advisory Committees to Medical-Surgical Plan, it was felt that before circularizing the entire profession in regard to such a proposal, it would be best to solicit the opinion and advice of the members of the various Advisory Committees.

Although this resolution was not originally on the agenda for discussion at the conferences of Advisory Committees, at each such conference, members of one or more Advisory Committees brought up the matter and asked what the Plan could do about the problem. The reactions among those attending these conferences were mixed.

On February 15, 1952, a copy of the Plan's resolution was sent to Dr. George W. Stephenson, Assistant Director of the American College of Surgeons, soliciting his opinion of this resolution, in view of the fact that the College of Surgeons had commenced conferences with the national Blue Shield organization on this problem. Doctor Stephenson's reply of February 28, 1952, stated:

"This has been discussed with Dr. Hawley, and it is our thought that your resolution is in line with good ethics and meets the objections which have been raised to methods of payment under some insurance plans."

This subject has been given further consideration by the Blue Shield Commission and the Blue Shield Plans in consultation with representatives of the American College of Surgeons at the annual meeting of the Plans, March 31 to April 3, 1952.

The following is quoted from a summary report of the meetings of the Blue Shield Commission held in San Francisco, March 29 and 30, 1952:

"The Commission heard a report by George W. Stephenson, M.D., Assistant Director of the American College of Surgeons, on the problem of 'fee-splitting', in which it was proposed that Blue Shield Plans cooperate in solving the problem by working out administrative procedures for making separate payments when services were rendered

by more than one physician in a surgical case.

"Sympathy with the problem was expressed, but it was the consensus of the Commission that Blue Shield Plans should not become involved, but that the professional organizations should solve their own ethical problems.

"It was pointed out that Blue Shield Plans would undoubtedly adapt their administrative practices to conform with whatever solution of the problem might be effected by the American College of Surgeons and/or other medical organizations."

In view of the above, the Board of Trustees of Medical-Surgical Plan has placed this matter on the table pending further information.

We would summarize the position of Medical-Surgical Plan with reference to this problem as follows:

(1) The procedure proposed for consideration by the profession was developed over a considerable period of conference and discussion. It was offered solely for the purpose of meeting a problem that had been presented to the Plan by many members of the profession—both specialists and general practitioners.

(2) The demand for such a procedure did not originate with the Plan.

(3) The resolution offered by the Plan expressly states that such a program would be put into effect only "provided that the principle of division of such payment is acceptable to the medical profession of New Jersey." The procedure proposed in this resolution was offered as a tentative suggestion for consideration by the profession itself, through its regular organized channels.

(4) Before offering the proposal to the profession, the Board of Trustees of the Plan satisfied themselves that the American College of Surgeons did not object from an ethical point of view to the principle of the proposal.

(4) *"Service Benefits" Program or "Indemnity Insurance Program":* In a single decade, the Blue Shield Plans nationally have enrolled 22 million people, and are presently enrolling new subscribers at the rate of 28,000 people every working day. As of January 1951, there were reported to be as many people enrolled in Blue Shield as were claimed for all other medical care plans and "accident and health" insurance companies combined.

Blue Shield has unquestionably been the pioneer and leader of this great rapidly growing voluntary health insurance movement, and it is generally conceded that Blue Shield has become the chief bulwark against the intervention of the federal government in the field of medical care.

The heart and soul of the "Blue Shield" movement is the "service benefit" feature. This involves a voluntary agreement between the individual "Participating Physician" and the Plan, whereby the physician signifies his willingness to accept the Plan payment as full payment for services covered by the Plan's Subscription Contract, provided that the income of the subscriber is not in excess of a designated "income limit".

More than 5000 Participating Physicians in New Jersey are using the facilities of Medical-Surgical Plan to make available their services, as covered by the Subscription Contract, on a fully paid basis for families in the lower income groups. With respect to subscribers having incomes in excess of $5000.00 per year, the Participating Physician retains the privilege of making additional charges apart from the payment provided by the Plan.

The Participating Physicians are making a tangible contribution to the preservation and security of the American system of medical practice. Through their participation, the Plan has been able to offer a service program that, in ten years, has attracted the support of three quarters of a million people in our State. It has enabled many thousands of families to assure themselves of a self-supporting status in the face of medical emergencies such as might otherwise reduce them to a state of medical indigency.

Prior to 1949, the "income limit" was $2,000.00 for an individual, plus $500.00 for the first enrolled dependent, plus $250.00 for each additional enrolled dependent. When these "income limits" were first established, in 1942, it was calculated that they embraced, potentially, the great majority of the people of New Jersey.

The adjustment from this earlier base to the present "income limit" of $5000.00 in 1949 was justified by statistics reflecting the changes in the cost of living and in the purchasing power of the dollar that took place between 1942 and 1948. The change in the Plan's "income limit" was considered and approved by unanimous action of the House of Delegates of The Medical Society of New Jersey at two successive annual meetings before being established by the Plan.

The new level was calculated in 1948 to restore the service benefit feature to the same segment of the population to which it had been made available at the time the Plan was initiated in 1942. It should be kept in mind that, coincidentally with the adjustment of the "income limit" in 1949, the Plan increased its Schedule of Payments by approximately 50 per cent in all items.

Experience has demonstrated the conviction of the founders of this and other Blue Shield Plans that operate on a "service benefit" basis,

that a service benefit program best meets the requirements of, and is most readily acceptable to, the lower income groups. If "service benefits" were to be eliminated from the voluntary Blue Shield Plans, there might again be a widespread demand for government to provide such benefits.

As for Medical-Surgical Plan selling an indemnity program only, there would be no excuse for the Plan entering into direct competition with commercial insurance companies. It is clear that the only insurance program the medical profession can properly offer is a service benefit program, and no service benefit program could or should be operated except by a medium approved and guided by the profession.

When the Board of Trustees of Medical-Surgical Plan of New Jersey proposes to make any major change in its contract of policy, it will present its recommendation formally before The Medical Society of New Jersey for its review and consideration, as has always been done in the past.

Medical-Surgical Plan
of New Jersey
May 12, 1952.

Monday Evening Session—May 19, 1952

The General Session of The Medical Society of New Jersey convened in Haddon Hall, Atlantic City, New Jersey, at 8:30 p. m., Dr. Sigurd W. Johnsen, President of the Society, presiding.

PRESIDENT JOHNSEN: I am happy to welcome you here to this open General Session of the 186th Annual Meeting of The Medical Society of New Jersey. We will now be led in the singing of our National Anthem by Miss Ruth Stein. All rise to sing the Anthem.

(The audience sang the National Anthem.)

PRESIDENT JOHNSEN: The invocation will be by the Reverend Harvey Bennett, Doctor of Divinity, of the Presbyterian Church of Atlantic City. Dr. Bennett.

DR. BENNETT: Almighty and eternal God, infinite Architect of the universe, by Whose power the worlds were formed, by Whose law the planets run their courses, by Whose inspiration scholars have searched for truth, prophets preached and poets penned their poems of life, to Whom all hearts are open, all desires known, and from Whom no secrets are hid; Whose excellence is more than we know, yet Thou art more and all that we adore, save us, O God, from feeling after Thee in vain through the darkness of a selfish and an unchastened mind; by Thy grace shame away all prejudice and scorn, melt our pride, quiet our fears, sweeten our affection and lift us above the fretfulness of the world into Thy Divine repose.

We commend to Thy Divine Province this noble company of doctors, the members of The Medical Society of New Jersey as they are assembled in the 186th Annual Meeting in this city by the sea. Thou has blessed their concentrated efforts as they have diligently and earnestly labored to alleviate the pain and suffering by the touch of their skillful hand, administered in love to the afflicted bodies of mankind. As they follow in the footsteps of the Divine Physician of life, grant to them wisdom from on high. And as they diligently search may they find new methods of aiding those who suffer. Give to them a new sense of their responsibilities and added strength for their daily task. Thus may they display a new patience, a new skill and a deeper understanding of those whose bodies are torn in pain.

These blessings, O God, we ask in the name of the great Physician of life who came that we might have life and that we might have it more abundantly. Amen.

PRESIDENT JOHNSEN: Thank you Dr. Bennett.

We shall now be favored with a solo by Miss Ruth Stein.

(Miss Stein sang a solo.)

PRESIDENT JOHNSEN: We now have the pleasure and honor of having a few words of welcome by His Honor, the Mayor of Atlantic City, the Honorable Joseph Altman. (Applause)

MAYOR ALTMAN: Senator Cain, Ladies and Gentlemen: I speak briefly on your busy program. I come here to welcome you on behalf of our permanent population by reason of the fact that you have selected this Atlantic City for your convention; and especially so, not to any greater degree, but especially so that the American Medical Association meets here so frequently. It is one of our choice conventions from the standpoint of our citizens of Atlantic City whose business it is to entertain conventions and guests.

Because you are citizens of New Jersey and take a pardonable pride in this Atlantic City that is known throughout the nation, I want to give you just a slight insight into what this town is about. We have a permanent population of approximately 60,000 people. We fluctuate, in the busy summer season, to about 250,000 people on weekends. Last year six-ten million tourists visited Atlantic City.

Conventions from all over these United States, regardless of their purposes—art, religion, labor unions, industry, medicine or the like—at one time or other in their existence in the convention business come to Atlantic City.

I don't greet all of them. Tonight the invitation of our doctor and your Doctor Allman is sort of a command, since I am a patient of his, and I dare not disobey his summons.

At this time, I present to your President, Dr. Johnsen, a beautiful key, a souvenir of the City of Atlantic City. It looks like gold, but don't get excited. It isn't. (Laughter) With the good wishes of the people of Atlantic City.

In addition thereto I hereby create of you a Special Detective in the Mayor's Office, of the City of Atlantic City, but with this admonition, doctor: In the event of a slight traffic violation, just flash this badge. It will accelerate your arrest and make the fine more grievous, I assure you. (Laughter and applause as the gold key and badge are presented to Dr. Johnsen by the Mayor.)

PRESIDENT JOHNSEN: I thank you. I have been to your fair city many, many times, but without the key, and had a perfectly wonderful time. With the key and with the badge I'm sure that pleasure will be greatly intensified. (Applause)

We shall now have a musical selection by Ferrin and his ensemble.

(A selection was played by the ensemble.)

PRESIDENT JOHNSEN: It is now my great pleasure to follow a precedent set by our Past-President, Dr. Aldrich C. Crowe, in having the President-Elect deliver his inaugural speech before the dying days of the session. Instead of having it come at the last portion of the meeting, we tried to give it a spot in the beginning. But more than that, it is a pleasure for me to have the honor of presenting to you a man who is very well known to you all, who has worked diligently for years in Essex County, but who for many years has worked in our State Society.

It gives me the greatest pleasure to introduce to you our President-Elect, Dr. Harrold A. Murray.

(The audience arose and applauded.)

PRESIDENT-ELECT MURRAY: Senator Cain, Detective Johnsen, Dr. Allman, and Friends: Let me thank you for the honor you have bestowed upon me. I realize with honor goes responsibility, and I am very happy to assume that responsibility if you will help me.

I think you know the story about the man who every day on his way to work stopped at the jewelry shop, and in that shop there was a clock. He took out his watch and he set the watch by the clock. Day after day and week after week he proceeded to do the same thing.

One day the owner of the shop came out and he said: "You know, I'm anxious to know why you do that. I've seen you come here day after day, month after month."

"Well," he said, "I am the man who blows the whistle in the factory down the street." The jeweler looked at him; he said: "Gee, that's strange, I've been setting my clock by that whistle every day." (Laughter)

Now, I suppose I'm the guy that's going to blow the whistle and you are going to see that I blow it loud enough, often enough, but always on time.

Our Society is eager to accept the challenges that a program of adequate medical care for our citizens presents. We know that the citizens of New Jersey enjoy, with all Americans, the highest standards of world health today. However, we realize that there are many gaps that are still to be filled.

We know, for instance, that this year 750,000 people, more or less, wil die with heart disease. We know that 20 million people now living will die of cancer unless newer cures and treatments are discovered. We know that one out of eighteen have a mental illness, and that one out of six are chronically ill. We realize, too, that two out of every three persons in this country need financial help when they are ill. Hence, we have some challenges, and I think they are about ten in number.

First, we must provide an adequate number of physicians. In New Jersey, our proportion is good. We have six thousand members in our Medical Society and there are approximately four million, five hundred thousand people in our state; this is one for seven hundred of our population. That isn't too bad. But in the rural counties the distribution is not good. We realize this in the Society and we have formed a Physicians' Placement Bureau. Since its inception in February, it has successfully operated to the extent that over sixty-four physicians' and lay or non-professional groups have called us in to see where are opportunities in our state for young men to practice. We plan to enlarge this, to stimulate these activities.

Second, and this is a new challenge, we need to provide beds for people who are acutely ill, particularly in our large cities. With the rapid increase in hospital service plans, we are now faced with the problem of getting a patient in a hospital when that is necessary. This year, we have organized a new committee, a liaison committee with the New Jersey Hospital Association. We hope, with the

prepayment plans, we can show them that probably it is a better thing if most of the subacute and the chronic patients go to their homes and receive the care that they want, with good nursing service and homemaker service.

Third, we have to provide adequate public health facilities. Do you know that thirty per cent of the people in our state are not protected with good and adequate health facilities? Last year, Assembly Bill Number 1 was passed and our Society actively cooperated in that passage. We are now intensely engaged in the implementation of this law. Services throughout the counties have been and are being established to implement the new law. This is our moral obligation, to see to it that people receive this protective health service.

Fourth, the most important problem we are facing today is the care of the chronically ill. Do you know that over two million workers are absent from industry on account of alcoholism, (which is a chronic disease) and other forms of chronic illness, each year? We know that and we in Essex County have established a homemaker service which has effectively operated for the last year to give a referral service to these people and to stimulate their going home from the hospital and using the homemaker's service and the services of the visiting and public health nurses. We plan that in every county a similar service will be started. This will be our answer to the challenge of the care of the chronically ill.

Fifth, we must step up medical research. When Dr. Waksman and his associates discovered streptomycin, they completely by-passed our wonderful institutions here; but that can't happen anymore because we are alerted to the fact that here in New Jersey we can offer those facilities. We will do it because we have formed a new committee, that will start operating very soon, to stimulate people who are really equipped to do research, to continue in this effort.

Sixth, we need a medical-dental school. You cannot expect to invite educated men, doctors, nurses and technicians to come here and work in our state unless we offer facilities for graduate instruction. The general tone of all medical care will increase if we give them this service. We need a medical center. We are not interested in the site of that center, but we have a very active committee that is working to inform lay groups of the great need for a medical school for better medical care in our state.

Seventh, and this is the item about which we are all a little emotional right now. We must definitely provide, or help provide diagnostic, rehabilitative and curative services for all income groups. I am happy to stand here tonight on the tenth anniversary of our Medical-Surgical Plan and to offer my congratulations to that Plan for the wonderful work that they have done within the past decade. For that period over 750,000 people in our state, one-sixth of our population, obtained coverage under this plan. This is our Plan; we love this Plan. It is going to increase. It is going to increase to embrace age limits above sixty-five and also later on, I hope, for the care of the chronically ill.

We know that we might need the help of other prepayment plans, but our plan is the best plan and we must do all we can in our power to keep that functioning—and we will—so that we can come back here again and tell you it has increased mightily.

Eighth, we must provide round-the-clock service to those who are acutely ill. Sometimes it is hard to get a doctor on a Sunday or holiday unless the physician designates a colleague to "cover" for him. We can do that if we just realize the great obligation that is ours to give this service to the community. We have done it in many counties throughout the state by cooperation with those medical telephone exchanges that offer continuous services for the community in emergencies.

In Essex County we have established the rule that before membership is obtained in the Society, the applicant will do two years of service in this field.

Ninth, we have to adjust our fees to the patient's income. We have a Judicial Council in our Society and during my administration that will function as it never did before. In this Council the complaints of the patients will be heard and considered objectively. We will do all in our power to give it intensive publicity so that the public will know that they have a place to go to when they have a complaint.

Tenth, we must improve our public relations. Public relations isn't just building up a beautiful edifice, sending out a lot of folders and all that. There isn't one member of the Society alone or any group that can put over a good public relations program without the help of every member of the Society. We have to convince the community, not by words, but by action, that the primary purpose of a well educated physician is to render service to those in distress. We are going to do that. It is going to be our moral obligation to do that. We are not going to spend a lot of money this year on wining and dining the press and the like; but we are going to show by our actions that we are loyal members of a community that want to give people service when they are ill, within their ability to pay for that service.

Well, these are our ten challenges and I am confident that we can answer each one of them. Over the years we have been attempting to do so; but now with the aid of our allies we will successfully do so. The Woman's Auxiliary, readily at our beck and call, our dentists, our nurses, our lawyers, superintendents of hospitals, public health officials, department heads of institutions and agencies, all professional and non-professional groups, probably even labor later, all voluntary organizations—and thank God for them—working together as a harmonious and well-managed team, will bring about the kind of services that we need in our state, in the way that has made America great without the dangers of compulsion or socialism. Thank you very much. (Applause)

PRESIDENT JOHNSEN: I am sure that with the outline of the program that Dr. Murray has given us there will be no one who says that The Medical Society of New Jersey is archaic; and I am sure that with the cooperation that you have given me in the past year, that this same cooperation will be given to Dr. Murray and it will result in a solution of many of the problems of which he speaks.

We shall now be favored with another selection from Miss Stein.

(Miss Stein sang another solo.)

PRESIDENT JOHNSEN: Thank you, Miss Stein.

Some time back, a good many years ago, I took a trip out west and I saw for the first time the state of Washington. I went through this beautiful Sierra Nevada mountain chain, with the great expanse of hemlock and spruce which stretched mile after mile, with the towering peaks of the Sierra Nevadas; went down through the Wenatchee Valley where the finest apple orchards of the country are found. I little dreamed that I would one day have the privilege of having a man come from that God's country to the sordid atmosphere of the city of Washington and bring to Washington city a bit of that fresh air from the state of Washington. Here is a man who stood up alone when an appointment was made that he thought was wrong. He fought it and succeeded in getting that appointment squelched even though it came from the President—a man who, when he thought an injustice had been done to a great man, insisted that the Senate set up an inquiry as to the reasons for the dismissal of General of the Army MacArthur. That man is here tonight and it is a great honor for me to present to you the Honorable Harry P. Cain, United States Senator from the state of Washington.

(The audience arose and applauded.)

SENATOR CAIN: Dr. Johnsen, Ladies and Gentlemen, and Distinguished Americans: I was complimented by your invitation. I am extremely pleased to be here tonight. A thrill of anticipation actually ran through me, some several weeks ago, when I subtracted 186 from 1952, for I knew then that I was to have an opportunity to try to say something worthwhile before a group whose forefathers moulded and conquered the real turmoil out of which came what has been, up to this time, the greatest republic the world has ever known.

Dr. Johnsen, you have just given me another thrill in your introduction, for which I am most grateful; your reference to Douglas MacArthur moves me only to suggest that there may have been citizens in the past who compared with that man's loyalty and devotion to duty, patriotism, courage and wisdom. But of one thing we must all be certain, that we are never going to conquer some of the problems that beset mankind until we have more people possessed of the virtues by which Douglas MacArthur has spent a very fruitful and productive life, even here or anywhere. (Applause)

I have been in this thing called public life for a little better than a decade. I have never until the very recent past had anything go wrong with what I used to speak with. I have always used what's known as a throat, I suppose, by instinct. It has from somewhere picked up a squeak; though not premeditated was I when I got that squeak. That is, I did not know at that time that I was coming to New Jersey to speak before its Medical Society. But if anything goes wrong with the way in which I wish to say something, I could think of no better place on the face of the earth to be than right here before this Medical Society. (Applause)

There are three laws supposed to be observed by a speaker in making an address: Let the argument be simple, the sentences short, the speech brief. I am now about to violate completely each of these principles. (Laughter) I am going to make a complicated speech of some considerable length.

I think at the outset I ought to be very fair with you. I am surrounded by some sort of protective device over which you cannot see. You therefore haven't any idea how many sheets of paper I have in front of me. (Laughter) And I know that audiences egitimately become restive if it appears, after once he has gotten started, that whoever he i might go on forever. (Laughter)

I have just some ordinary shee s of paper by way of size. There are thirty-two in number, one of which has already been disposed of. (Laughter)

And I, unlike some other people, will not take the one from the top and put it on the bottom so you think after an hour the fellow just isn't getting anywhere. (Laughter) Once I get rid of one of these sheets of paper, it is going to go on my left, not to be seen again.

The subject assigned to me by Dr. Johnsen was "The Dangers That We Face".

The supreme danger abroad, of course, is that presented by the Soviet despotism and its communist satellites and the conspiratorial apparatus throughout the world.

Your guest is not afraid of the communists either here or abroad and my lack of fear is shared by many another American man and

woman throughout this republic, and don't you be in doubt about that.

I am completely confident that such enemies can and will be defeated. I am, however, desperately afraid that we may destroy ourselves —this republic called the United States.

I want to analyze for you two aspects of this very clear and obviously present danger. The first is the active effort now going on to use the Constitution as an instrument to impose domestic legislation by treaty. The second is the dreadful mare's nest represented by our present social security system.

I shall not be satisfied with analysis alone nor with criticism. Before I finish I shall present what I believe to be some positive and constructive proposals.

Exactly one hundred and sixty-five years ago this month there assembled in Philadelphia, some seventy miles from where I now stand, a group of men whose task was to draft a Constitution for the United States.

These men were highly conscious of what they were doing. Indeed, in the very first of *The Federalist Papers,* written and published during the spirited political campaign for the adoption of the Constitution, there occurs this passage:

> "It has been remarked that it seems to have been reserved to the people of this country, by their conduct and example, to decide the important question, whether societies are really capable or not of establishing good government from reflection and choice, or whether they are forever destined to depend for their political constitutions on accident and force."

These men who gathered at Philadelphia were experienced and practical persons. The job they had on their hands was no joke. The Articles of Confederation were far from satisfactory and the infant nation threatened to split apart because of disagreements among the states. What was to be done about it? These men were confronted with a condition, not a theory and it was essential that they get results.

The average age of the delegates was 43. In one way or another all had been involved in the desperate war for independence that cut the tie from Britain.

Washington, a delegate from Virginia, was 55 and at the height of his vitality and vigor. Captain Jonathan Dayton, one of the New Jersey delegates, had served with distinction in the Revolution. He was only 27.

Another thing about these men: all had grown up in the tradition of 18th century enlightenment and skepticism. They looked upon mankind baldly and they spoke of human beings with a bold and acid realism.

One of their basic attitudes was that man is a turbulent and unruly animal—sometimes courageous, sometimes cowardly—often generous and as often greedy. These men were not interested in the idea of perfectibility.

They did not weep over man's shortcomings nor exalt his merits. They tried to take him as he was. What they wanted was to devise a government in which this turbulent and unruly animal should have the maximum of liberty and yet be restrained from stomping on his neighbors.

John Adams was absent, serving in London as Minister from the United States to the late enemy; but a remark of his is typical of the attitude of the Constitution drafters. Said he: "That the first want of every man is his dinner and the second want his girl, were truths well known to every democrat and every aristocrat, long before the great philosopher Malthus arose to think he enlightened the world by his discovery."

Delegate James Madison put it this way: "If men were angels no government would be necessary".

At one point, while the delegates were struggling over their work and tempers were frayed, Benjamin Franklin moved that each session be opened with prayer. Alexander Hamilton opposed the motion, saying, and I quote him literally, that the convention didn't need any "foreign aid". (Laughter)

These men were after some form of government that would work. Their knowledge of European absolutisms was anything but academic. They had had direct experience. What is more, they knew what it was like to be pushed around by bureaucrats. They had got a bellyful of executive orders issued beyond the sea.

So they put their minds to the problem. Monarchy was repudiated. Orders of nobility were forbidden. An established tax-supported church was thrown overboard.

What was to be done about the power of government?

They divided it. Some powers were given to the Executive, some to Congress, others were reserved to the states and to the people themselves.

As you read the Constitution—and I hope everybody will re-read it—you see clearly how practical was the aim, and how simply, how clearly they stated the rules.

Finally, since these men knew that there was nothing so inevitable as change, they provided that the Constitution, designed for the

use of turbulent and unruly animals, could be amended.

In that distant day treaties dealt with purely external affairs. Treaties were contracts with foreign governments concerned with war and peace, trade, cessions of territory and so forth.

The Fathers provided in the Constitution that a treaty, duly negotiated and confirmed, should become law.

I will now read to you the second clause of Article VI. It is very important in this discussion as you will presently see.

"This constitution, and the Laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every State shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding."

A treaty became the supreme law of the land. No judge could break it.

What was the reason for this?

It was because treaties of the time, international contracts, dealt with such external affairs as I have mentioned. If, for example, the United States negotiated a treaty with Great Britain dealing with fishing rights off the Grand Banks of Newfoundland it would not do, let us say, to have some Massachusetts judge, with his eye on the Gloucester fishing interest, give decisions that went against the treaty, and so violate the contract.

So treaties became the supreme law of the land. And that clause is making trouble now as you will shortly see. The Founding Fathers never contemplated the possibility that a treaty could take the place of domestic legislation, nor had any idea that an instrument drawn in Switzerland might have the effect of a local police regulation here in New Jersey, which is the prospect that faces us tonight.

I said they never contemplated such a thing. But they did foresee change and provided for amendment of the fundamental law.

Let me sum up the discussion so far:

1. The aim of the founders was to devise a Constitution that would work and yet provide a maximum of freedom.

2. They provided, among other things, that treaties, once approved by the Senate, should become the supreme law of the land.

3. They provided that the Constitution and the laws could be altered in an orderly and intelligent way.

4. They believed that the freedom of our people did not have to be crippled because of change. They did not believe, as *The Federalist* put it, that we were "forever destined to depend for our political contributions upon accident and force".

I don't propose to lead this audience through an economic history of the United States, but a little more of the background is essential to make clear the points I seek to offer for your consideration. The last thing the Founding Fathers wanted was to imitate Europe. They knew too much about Europe. To get away from its oppressions of which our new citizens had had such direct and bitter experience was one of their fundamental aims.

Granting that this was so, I now ask this question: How could it be that in this country, so founded and so organized, the inspiration of our present social security statutes was derived from a European despotism? How did we come to adopt ideas originally designed in Germany to harness people and shackle them to the state?

For that is exactly what was done by the Federal Government in 1935—at least this is my point of view—when the Social Security Act was passed.

In substance, what happened was this: The industrial expansion in the United States after the Civil War was the greatest the world had ever seen.

Immigrants by the million entered the country to provide the labor for coal, iron, steel, oil, and manufacture of all kinds.

American cities burst at the seams. The new immigrants piled up and we began to have slums.

The foreign born, eighty years ago were eager and they also were bewildered. For many of them life was both hard and strange.

Americans have had the reputation of being a generous people in many ways and humanitarian movements have always flourished here. It was inevitable that the attention of the humane should be attracted to the struggles of the foreign born in the slums.

It would take too long here to trace the strange course by which the evangelical zeal of American humanitarians, the fervor of immigrant socialists, the floundering of organized charity, and the discontent of numerous academics cross-fertilized each other and led to the acceptance of authoritarian doctrine by American uplifters.

Jane Addams, the founder of Hull House, the first settlement house in America, said that settlement workers felt a "subjective necessity" for their efforts because of "that sentiment of universal brotherhood, which the best spirit of our times is forcing from an emotion into a motive".

Observe the difference between this statement and those of the Founding Fathers, and then, for you have the right of choice, select as you will.

They thought of man as a turbulent and unruly animal. They wanted to give him all the freedom they could, but prevent him from bashing his neighbor over the head.

Did Miss Addams take this attitude? No. In some peculiar manner, the turbulent and unruly animals who made up society had been overtaken by a powerful yearning for universal brotherhood.

The settlement worker like herself, said she, had "a sense of security in regard to illness and old age and the lack of these two securities are the specters which most persistently haunt the poor".

If you examine the thought of Miss Addams and those who came after her, you discover that it wasn't just medical care they were concerned about, it wasn't just unemployment, nor orphan destitution, nor old age. They never clearly articulated what was plainly their driving impulse:

It was to protect mankind from care and pain from, as the Constitution would say, whatever source derived.

Actually the problem was clear, however, difficult.

The problem was this: What shall Government (local, state or Federal) do to care for the destitute and those who are wounded in the battle of life? Since the days of the first Queen Elizabeth this had been a community responsibility. What shall be done now when the economic face of the country was going through tremendous change? How shall the responsibility be discharged and yet leave the maximum of freedom and liberty to you and me, citizens everywhere?

I find no trace whatever of an effort on the part of the American humanitarians to go at this problem from the point of view of the Founding Fathers, for whom I continue to have such a solid respect and from whose conduct I continue to derive hope and inspiration for the future.

No. They looked for a lever to accomplish their aims, and they found it—Where? —in autocracy.

How had this happened?

A little over a hundred years ago, in December 1847, Marx had published his *Communist Manifesto* and its final sentences electrified the Europe of that day.

This is what he said: "The communists disdain to conceal their views and aims. They openly declare that their aims can only be attained by the forcible overthrow of existing social conditions. Let the ruling classes tremble at a communist revolution. The proletarians have nothing to lose but their chains. They have a world to win. Workers of all lands, Unite!"

In the years since the Manifesto's appearance, agitation in Germany had terrified the ruling class. Bismarck, the iron Chancellor of the newly organized German Empire, dreaded the possibility of a violent political convulsion, and being a smart man, he cast about for a counterpoise.

He found it, without much trouble. He got his counterpoise in the idea of social insurance, furnished him by Adolph Wagner and other German economists.

What was that idea? I ask you now to watch this closely:

1. Lay a small payroll tax upon the wage earner and put the tax money into a fund.
2. Lay another small tax on the employer and put this tax money away in a similar manner.
3. Let the Government have the money and apply compulsion to worker and employer.

Now what have you?

The wage earner has got what he believes is a vested interest in the status quo. He will hardly be susceptible to revolutionary arguments if he runs the risk of losing his various payroll taxed benefits.

What shall Government do with the fund? What, by the way, do you think it has done so far with the fund? (Laughter)

Why, spend it for other things. Payment of these promised pensions is postponed to another day and Government will somehow find the money when the time comes.

There was one more aspect to the proposition that appealed to the Germans: To administer such a system would require a horde of petty civil servants and they also would look to the State for survival.

Eventually the system was copied throughout Europe.

How perfectly these ideas fit the picture of an authoritarian government manned by a huge bureaucracy!

What American propagandists thought about the German autocracy I have no real way of knowing, but they embraced — and tell me, please, if you think me wrong—with a passionate fervor the German notion of bureaucratic social services. From the early 1900's down to the Wall Street crash of 1929 they spread the gospel of authoritarian welfare.

Our present system which we got as a result, a direct one, by the way, of this agitation

is, to my considered view—that's why I like to have this invitation tonight—a cruel and unjust thing for many reasons. I offer you but two tonight.

First, through the deliberately rigged complexities of the Old Age and Survivors Insurance system, millions of old people are shut out and haven't a prayer of ever getting in. Relief is the best those millions of our American aged can ever hope for.

Secondly, young people just now starting work are taxed and given an implied promise that at retirement they will receive an annuity. There is no certainty whatever that this will happen. Not only will they be taxed double to redeem the Government's I.O.U.'s in the government's phony trust fund, but the current practice of increasing benefits to favored age groups, while yet the social security tax income is greater than the benefit outgo, simply means that presently the outgo will exceed the income and further taxation will be necessary to bail out a bankrupt system. Any contention that our present system is actually sound is completely false and utterly, from my point of view, dishonest. (Applause)

A blend of bureaucrat and uplifter is maintained in official utterance today. Here is Oscar Pogge of the Federal Security Agency dispensing philosophy in the Social Security Bulletin last January. Permit me to give you but one of his paragraphs, illuminating as it is, to chew over at your own convenience.

"Our primary function," said Mr. Pogge (meaning the function of the Social Security Administration) "of providing income for retired people, seen in its broader perspective, is but a partial contribution toward the well-being of all aged people. And this well-being is more than a matter of having a cash income that helps meet the expenses of food, clothing, and shelter, the bare elements of keeping alive—It is a matter of attaining positive satisfactions in life. . . More and more the Bureau is joining with others to answer the question . . . how can we help them (the old people) to a more purposeful and happy life?"

The Federal bureaucrats are undertaking to package happiness. The Founders knew better. Happiness may be pursued and the right to pursue it was stated in the Declaration. Its achievement is something else again. Into every one of our lives some rain must fall. Heartbreak, discouragement, parting and death do not yield to Executive Orders, Oscar Ewing to the contrary notwithstanding. (Applause)

You may now ask, did no American put his mind to this problem in the simple and direct way in which the Constitution drafters went at their problem? The answer is yes.

Forty years ago there lived in New York a consulting actuary named Miles Menander Dawson. Through circumstances unknown to me, this man was invited to read a paper before an International Social Insurance Congress which met in Rome in October 1908.

Dawson accepted the invitation, went to Rome and read his paper. It was a remarkable essay, but, so far as I can discover, it did not make the slightest dent, either in the minds of Europeans or of Americans who were then beginning to explore the endless mazes of the German system.

The essence of Dawson's argument was profoundly simple. A child can grasp it. It is this: Those who cannot work must be supported by those who do. Furthermore, you cannot postpone paying the bill. You must pay as you go along. You must pay that bill on a current and annual basis as you accumulate that bill.

You see that Dawson's thesis is diametrically opposed to the German thesis which our administration adopted in 1933, and probably with the help of a lot of Republicans.

At the conclusion of his address, Dawson made the following remarks: They ought to be cast in bronze:

"It is not money but human services which support the dependent members of society; it is not the wealth accumulated by the present generation of men, for instance, that will support them (that is, the dependents) in their old age, that will feed them, clothe them, warm their aging limbs, but the grain which the generation of that future day will harvest by its labor, the fleeces which that new generation will weave into cloth, the coals which it will dig from the ground. The creation of wealth by this generation in the form of capital, of helps for production, will render it lighter and easier, to do this; but the new generation must do it."

Here we have the problem of looking after the helpless stripped down to the bare bone. There is no argument here for a phony trust fund, of the juggling of so-called contributory taxes, of our young people today paying social security taxes for something that supposedly will be paid back to them forty years hence.

No! Says Dawson: Those who are helpless today must be supported by those who work today. Those who are helpless next year must be supported by those who work next year. That is to say, if you are to handle this problem through Government, then the expense must be a part of the annual budget and accepted as such.

It is to secure an honest, simple, and coher-

ent social security system on such a basis as Dawson suggested that your guest began, several years ago, shortly after I came to the Congress, to press for the junking of the present system and the installation of the Dawson principle.

Two years ago, on June 20, 1950, at the close of the Senate debate on H. R. 6000, the omnibus social security bill, I happened to say:

"If we are to have a social security system at all, let us have one that freedom can accept with self-respect. Let us accept and act upon this bald truth:

"That our old people, who have done their life's work and have quit, must be helped by those of us who still work. In due time, our children must look after us. Not in the old way of the old folks on the farm, but in the same spirit adapted to the institutions of our day—through taxation (that is, through income tax straight across the board). Let us have done with this nonsense of a contributory system, this playing house and calling it insurance.

"I accept wholeheartedly this proposition of having us who work help the old folks who have quit. I stand ready to pay as high a tax as my fellow citizens are willing to pay to put such an honest social security system into operation."

As the members of The Medical Society of New Jersey know there was an effort in 1934 to include compulsory health insurance in the first great omnibus social security bill. Let me talk with you about that for just several minutes.

It did not succeed, but the propagandists have never quit in their efforts to put it over. They are utterly confident. I know whereof I speak for I sit and work by their side every day. These propagandists are utterly confident that they will eventually succeed, by the piecemeal route, if not direct.

Some physicians begin to wonder, in their struggle for a living, if, after all, compulsory health insurance may not be a good thing.

Other doctors, weary of the endless struggle against State control, say—I have heard them say it—"Let it come. It is useless to fight any more." Shutting their eyes to the fact that they will find themselves, at the end of the road, on the Federal payroll, bossed by Federal straw bosses and browbeaten by endless directives and regulations.

Still other medical men remain belligerent about compulsory health insurance, but see nothing wrong with other phases of our present social security system and would be perfectly willing to accept, for example, old age benefits for themselves at supposed face value.

Compulsory health insurance cannot be separated from the other phases of the comprehensive social security program. The security bureaucrats want not only to protect mankind from care and pain from whatever source derived; they want to control the recreation of the young, the education of youth, and the flow of public funds to all in distress—the aged, unemployed, dependent, sick and disabled. They have built up a vested interest in misery and they labor without cessation to find new kinds of misery to exploit.

If any group of men on this earth ought to know that man is an unruly animal, you doctors ought to know it. You look after him; you patch him up; you keep him going. You see at blisteringly close range the strength and the weakness, the courage and the cowardice, the charm and the meanness of human kind.

Doctors see all this and they know, likewise, what compulsory health insurance will do to you and to men everywhere. But simply pointing out the dangers we face is not enough.

The British doctors fought the socialist bureaucrats. And I have studied as a student, in years gone by, in that lovely island land. I spent months there on the staff of one of our leading commanding generals. I have been three times back to England since the war was over. I think I know what the British doctors did, for which they can be complimented. I know more tragically what the British doctors failed to do, and that's the pity of it all.

The British doctors fought the socialist bureaucrats, but they didn't fight hard enough and with sufficient understanding. Now they are fighting a rear-guard action to rescue a little professional freedom and a miserable livelihood from the wreckage. As for today—though we hope for better things in the future—your counterparts and confreres in Great Britain are licked—.

You also will be licked if you do not engage in a steady, aggressive and constructive effort.

I do not believe that the doctors can win if they simply defend the profession as a vested interest. I think they can win if they regard the medical care of our people as their political as well as their professional responsibility.

Government opposition to you is tireless. Consider H. R. 7800 introduced in the House on May 12 and intended to be railroaded through Congress. They almost got away with it. Ostensibly this bill expands Old Age and Survivors Insurance benefits, but buried in it is an insurance program, not a relief program, for the permanently and totally disabled. If this bill passes, compulsory health insurance has already begun.

Let me suggest to you, for I believe it to be

so, that this bill, under the leadership of Congressman Doughton, was on the House floor this afternoon, and in my view will soon be there again. Mr. Doughton says that the bill will be passed. My information is that on the first test vote it lost by a margin of two.*

Those of you who have somewhat foolishly supposed that the compulsory health insurance issue was dead ought to begin to realize that it is more alive tonight than it has ever been since I have been in the Congress of the United States.

I said I was going to make a long and complicated speech. I have done it with a vengeance. But I am not yet through. I want to hold your noses, with your permission, to the grindstone for maybe ten minutes longer.

My discussion now turns to the recent activities of the International Labor Office, known as the I.L.O.

The I.L.O. was established in 1919, *via* the Versailles Treaty, as a separate body, associated with the League of Nations.

You better get a great big interest in it right away because it is shortly going to try to tell you, and it may be successful, how to run your business in New Jersey.

It has its headquarters at Geneva and is today a sort of coadjutor with the United Nations—but with a completely independent constitution and budget.

The impulse to organize it came from the demands of labor organizations in the allied nations that labor should have a voice in the peace that followed World War I—a most laudible ambition. For some years the activity of the I.L.O. consisted in the gathering of statistics, the recommendation of higher labor standards, the promotion of child labor protection and so forth. In many ways the organization seemed to fill a useful purpose.

There are now sixty participating governments — including our own. Each government, every year, sends four delegates to the Annual Geneva Conference. Two delegates represent our Government; one represents American labor, and one represents American employers. In general practice, the two Government delegates and the labor delegate have voted together. The employer delegate is a very lonesome person.

For many years, few Americans paid any attention to the I.L.O. Most people, if they ever heard of it, thought it was just one more international debating society.

Suddenly, not long ago, people began to wake up to what was going on. And what was going on was this:

The I.L.O. was strongly socialist from the start. In its early stages its action had been largely recommendatory. But in recent years it has piled up a permanent staff at Geneva of 400 persons. It is this staff which prepares the agenda for the annual conferences.

You will not be surprised to be told that, as more and more countries have moved into one form or another of central control, the greater number of the delegates and the greater number of the staff are whole-hog government control people.

Nor will you be surprised to learn that the doctrine they are most interested in promoting is Bismarck-derived social security regulation.

But how do they propose to put it over?

They propose to do it by treaty. Their word for "treaty" is "convention".

Within the next thirty days the annual conference of the I.L.O. will meet at Geneva. There they will vote upon a treaty which was threshed out at last year's conference. Of course, the conference will approve the convention and, in due course, a copy will be sent to Washington for action by the American Government.

If this convention is submitted to the Senate—as presumably it will be—and if it is approved, as it may be, by a two-thirds of those Senators voting, that convention or treaty will become, as I pointed out earlier, the Supreme law of the United States of America.

What is this treaty, this convention? What does it consist of?

The title of the convention is "Minimum Standard of Social Security".

What does the treaty, the convention deal with? It deals with nine things: Medical benefits, sickness allowances, unemployment allowances, old age pensions, workmen's compensation, family allowances, maternity benefits, disability pensions, and survivor's pensions.

I shall not attempt to read the text of the Convention to you for it contains seventy-three articles and is very long. But somebody in this Society ought to read them. I want to needle you, in a modest way, by quoting only several passages briefly.

Here is Article 6 from Part I:

"Where the insurance against the contingency concerned is voluntary, the public authorities shall subsidize such insurance to the extent of at least one-quarter of the expected cost of benefits and administration."

In other words, the I.L.O. insists that it will not consider voluntary insurance as a part of

* HR-7800 was defeated 150 to 140.

social security unless it is at least partly subsidized and wholly controlled by Government.

You realize what this clause would do. It would put the Federal Security Agency right into every Blue Cross office, every Blue Shield office, every private medical insurance plan in the country.

This is what is being cooked up for you in part in Geneva, across the seas this month.

I said I would not be content with analysis and criticism. I said that I would endeavor to make some positive and constructive proposals. I want to do so now as we work rapidly toward a conclusion.

What to do about the oncoming I.L.O. Treaty or Convention?

The answer: Actively support—whatever your politics may be, Democrat or Republican, and this American could not care less—what is known as the Bricker Amendment.

This proposes an amendment to the Constitution which makes impossible the use of treaties, conventions or executive agreements to impose domestic legislation upon us in the United States. Both of your New Jersey Senators have signed this proposed amendment drafted by the distinguished Junior Senator from Ohio, Mr. Bricker. It is now before the Senate Judiciary Committee.

Hearings on this will commence tomorrow or the day after. Senator Robert Hendrickson of New Jersey is a member of the Committee conducting the hearings. The American Bar Association and numerous other organizations actively support the measure.

I lobby for those things which I think are good, healthy and constructive. I earnestly urge all of you to write or talk, to express your interest to Senator Hendrickson, urging him that the amendment be reported out for Congressional action during this session of Congress.

We seek to save our republic before combinations of those abroad destroy it.

The need for action in the minds of people like Bricker and Hendrickson, Alexander Smith, Harry Cain from across the country, and fifty-odd other Senators—we feel the need for action is critical, and now.

Second, what shall we do about the reformation of the Social Security System, in which you as a profession have such a profound interest?

My proposal is based upon the Dawson thesis, and here it is:

That the Federal Government directly assume a specific responsibility toward all persons 65 and over, all dependent children, and all persons who can show, upon certification by a physician, that they are permanently and totally disabled;

That to all such persons—the old, the dependent child and the disabled—who shall apply, the Federal Government pay every month a flat sum which shall be tax free.

The amount of the sum shall be fixed by competent actuaries and economists. The sum shall explicitly be a contribution *toward* the living of the recipient. The Federal Government must not be permitted, at least from my point of view, to assume the responsibility of providing a living income for anyone.

The Federal Government should simply see to it that a regular contribution goes to all in these categories and that any deficit for those who are completely destitute shall be taken care of by State and local authority.

How shall this program be financed?

Through a surtax upon incomes, the surtax to be ear-marked to social security alone.

Revenue raised thus from every single income tax payer will bring home to every taxpayer the inescapable fact that those who cannot work must be looked after by those who do work. I can conceive of nothing more certain to keep the watchful eye of the taxpayer on social security costs in the future.

The most important feature of this concept of social responsibility for those in need of aid is that the budgetary requirements can be calculated for each year, which cannot be done now. In this way we escape future obligations which possibly could not be met. There would be no more political jockeying with the social security program, no more trading on poverty and distress. At the same time the community forthrightly and directly recognizes and accepts the responsibility it has.

At a stroke this concept cuts through the present social security jungle. The tangle of contributory taxes, varying with income, vanishes. The horde of jobholders now required to man the social security system becomes unnecessary.

Thirdly and finally, what shall we do about medical care?

Physicians, from time immemorial, have occupied a position of moral prestige in the community that no amount of perversion by the fringe of irresponsibles could erode away. The dubious fraction in your profession is extremely small. The blacklegs and the shakedown doctors are conspicuously few. Yet no group is under more constant attack today.

Here is Governor Murray of Oklahoma addressing the Tulsa County Medical Society last January. In a paragraph he says:

"You have been able to scare the very britches off the politicians and to date you have been able to fend off the advances of the socialist trend, but you and I both know you haven't stopped it by any means . . . During all this time you have failed to rally a militant public opinion to your support."

This militant public opinion you must somehow secure.

A physician acquaintance of mine tells me that he works fifteen hours a day and simply doesn't have the time to study the problem of how to get support from the public.

I ventured to him that he would either have to find the time or he better delegate that task to some competent persons or he and they and their profession were sunk.

All the chatter about free choice of physician is eye-wash. The very ground is heaving under the feet of the American medical profession tonight.

What to do?

In the first place, the profession has got to find some way to convince the community as a whole that the doctors are actively concerned about the nation's health. This is a psychologic problem, but an answer for it must be found.

I doubt if a people—we Americans—were ever more afraid of more different things than is the case today.

Do you know something? The bureaucrats actively cultivate these fears for they have an all-embracing answer— you hear that answer everywhere and the cheers go up from too many millions of unthinking Americans—Let the Government do it.

In the second place, there is no single answer to the problem, is there? There never has been, and there is no good, sound reason why there ever should be.

The voluntary insurance plans—both Blue Cross and private—continue to grow, and you ought to press them to the very limit.

But there is, I suppose, a limit beyond which these plans can be pushed, and Oscar Ewing loves to tell you that.

What of it? Push your plans as far as you can push them. The effort to get somewhere with insurance for catastrophic illness is belated, but better late than never, by a long way.

Again, an active effort should be undertaken by the medical societies and the banks to provide for medical care loans at a reasonably low rate of interest. A way must be found, and I think can, to guarantee these loans.

It is not the Government which guarantees bank deposits, but the banks themselves—collectively—through the Federal Deposit Insurance Corporation.

Such an arrangement would knock out the loan sharks, and if installment payments are good for television sets, they ought to be good for medical care. (Applause)

Finally, no amount of financial juggling can alter the fact that the indigent will always be with us and we have got to look after them. I pray for just a little honesty and a little recognition of common sense and the facts of life, which Federal autocracy can't change really, however hard and consistently they endeavor. No form of government down to and including communist Russia has been able to beat this rap, and you may be sure that Oscar Ewing won't beat it either in the long run.

Incidentally, as most of you well know, Mr. Ewing has a habit of confusing himself with the leading personage of the New Testament. (Laughter)

In October 1951, in the course of addressing the National Association of Housing Officials, Mr. Ewing said: "I do know that one of the greatest single sentences in the Bible is this: 'He went about doing good.'"

I am not as familiar with the Good Book as, no doubt, I should be, but I recall that the Savior bore down very heavily on the idea of personal responsibility. In other words—this is my interpretation as opposed to Mr. Ewing's —if you want to get saved, it's up to you. "The Kingdom of God," said the Savior, "is within you."

And when the rich man asked what he should do to inherit eternal life, you will remember that Jesus told him to sell what he had and give it to the poor.

Note that, under the doctrine of personal responsibility, it was up to the rich man to act. This was a decision for the rich man to make, not for the tax gatherers of the Roman Governor, nor yet for Jesus Himself.

But this doesn't seem to have occurred to Mr. Ewing.

He has two costume changes. I seek to do the fellow no particular harm. I seek only to paint him as I think he is, and only for the purpose of fighting for my understanding of the needs of the United States today. Maybe parenthetically you will permit me to say there aren't enough people who aren't unafraid of saying what they think about some of the rackets now going on in modern America. The Oscar Ewings are going to beat our kind of people if our kind of people keep being a little shy and too much afraid of speaking the truth as they think it so obviously exists.

Mr. Ewing has two costume changes. At times he appears to me in the purple of Pontius Pilate. At others he wraps himself in the mantle of the Carpenter of Galilee. In both roles he is supported by the horde of Scribes and Pharisees on the social security payroll. St. Paul had a word for it: "Sounding brass" and a "tinkling cymbal".

I cannot believe that the genius of our American people, which has achieved so much in the past and is still achieving, must go down before the crushing weight of government. I believe no such thing.

It need not be—what man hath done, man can do again.

Can we not attack these questions in the spirit of those who gave us our institutions and devise ways and means that leave our freedom, the real thing that matters, intact?

As Judge Florence Allen of the United States Court of Appeals has said in her masterly study of the threat of the International Labor Organization ("The Treaty as an Instrument of Legislation")—she said it better than I after weeks of effort and her conclusion is mine:

"The mass production, the initiative and the decisive swiftness of mobilization which enabled America to arm the world against Hitler are the product of America's unique"—I love that word—"heritage. The inventive spirit was released here not only because the new wealth of a new continent invited exploration, but also because for the first time in history men were free to work for themselves."

If we had time and you had a lot more patience, I'd like to talk to you about the American Bill of Rights.

You know, it is the only instrument ever written through which men and women told government what government could and could not do. No other instrument like it in all of the history of mankind.

Americans say to me: Well, there is a great similarity between the American Bill of Rights and the English Bill of Rights. And nothing could be further from the truth.

The English Bill of Rights came because British sovereigns were getting frightened and they said: People, quiet. We will give to you certain freedoms.

In America we said in our Bill of Rights to Government: There are courses of action and the employment of force which you will not use because we are going to remain free.

One of the great tragedies on the face of the earth today, to my way of thinking anyway, is that too many Americans know so littel about the instruments which made them free .

Judge Allen goes on:

"The ingenious artisans, who labored for the king, began to devise processes and tools for their own invention, and creative invention was set free. The standard of freedom of education, which is now asserted by all countries of the world, was first declared in the Northwest Ordinance and echoed through the American states. The unfettered mind of America was the result."

If in this hour, as Lincoln so truly said—and statesmen the world over parody and repeat today—America is the last best hope of earth, it is because America built here something new. America built something that needs, for the good of mankind in the centuries to come, to be preserved.

I wish you well.

(The audience arose and applauded.)

PRESIDENT JOHNSEN: This spontaneous ovation and response is but a feeble expression, Senator Cain, of our thanks to you for this stirring and inspiring address.

In behalf of The Medical Society of New Jersey, I wish to express our thanks and appreciation for your kindness in coming down and delivering this address to us.

Before closing, I would like, in behalf of The Medical Society to give our expression of sincere thanks to the nurses of the Atlantic City Hospital for coming here and doing the ushering.

To Miss Stein for her splendid contributions to the evening.

And to Ferrin and his ensemble for their splendid music.

Last but not least, our thanks to one whom we often see but seldom hear and who has been responsible in great measure for this program, our past Chairman of our Board of Trustees and Trustee of the American Medical Association—Dr. David Allman.

You have all been very good and very patient and I thank you for your interest. We now declare this meeting adjourned. Thank you.

(The meeting was then adjourned at 10:05 p. m.)

Tuesday Evening Session—May 20, 1952

The speakers' section of the dinner-dance program convened at 9:10 p. m., in the Vernon Room, Mr. Richard I. Nevin, Toastmaster.

THE TOASTMASTER: President and Mrs. Johnsen, our Distinguished Guests, Ladies and Gentlemen: It is to me a cherished and privileged function to preside over this gathering tonight, which exemplifies—in a way in which I think Oscar Ewing never conceived—the highest and the best in the socialization of medicine. There is that uniqueness about the spirit of our gathering tonight, I think, because while other meetings of our convention have concerned themselves with matters of the head, here tonight we are gathered to express the sentiments of our hearts.

It is not an intimidating circumstance even for the toastmaster, because the geniality that prevails soon banishes all fear. By contrast, I find myself thinking of a story that is told of a very young curate who was assigned to St. Patrick's Cathedral in New York in the same week in which a new rector was sent there, in the person of Monsignor Levelle, years ago.

It chanced that the young curate arrived first, and he was assigned to preach at the eleven o'clock Mass on the following Sunday. When the Monsignor arrived, he was asked if he preferred to preach himself. He said: "No. I'll say the Mass, but I will not preach."

So the young curate was about to make his first sermon in the great church, in the presence and under the observation of the new "boss". When the time came, he left the sanctuary, walked out to the altar, and knelt trembling while the choir solemnly intoned the "Come Holy Ghost". Then he moved reluctantly along the long road to the pulpit; up the winding staircase. The door closed with a certain inevitability behind him, and he stood alone, facing the vast church and the great congregration—that was before the days of the microphone—and in a very thin and quavering voice he said: "I shall return unto my Father's house. . . In the name of the Father and of the Son and of the Holy Ghost, Amen."

And then he realized, as he stood there, that the whole sermon, which he had so carefully memorized, was gone. He paused, and he grew ashen, and perspiration came out on his brow; and then in a desperate, hollow voice, he again said: "I shall return unto my Father's house. . . In the name of the Father and of the Son and of the Holy Ghost, Amen."

With that he turned and left the pulpit, and like a beaten dog he made his way back again. And approaching the altar, he bowed shamefacedly toward the Monsignor, who sat there, without moving a muscle of his face, and said: "Say, kid, give my regards to your old man." (Laughter and applause)

I have the happy feeling that if I were to forget tonight, you would all prompt me to express your regards . . . which I do, most happily.

I find myself recalling something that years ago I was forced to read in Demosthenes. It had to do with a situation in which he was called upon to give praise to the heroes of Thermopole. He was the most articulate and gifted of the Greek orators, yet by way of highest encomium when he came to speak their praise, he said of them: "Good men, all."

And I should like to say to all of you, of the men with whom I have been privileged to work in The Medical Society of New Jersey, that they are "good men, all". And Dr. Johnsen, whom you honor here tonight, is one of the best of the good.

This is the more remarkable, it is the more grateful to us all, because we are living in an age where very many men exemplify and seem wholeheartedly to embrace irresponsibility and selfishness; and in him we have had and we will continue, I hope, to have one who serves in a spirit of responsibility, dependability, and unselfishness.

I think there are four aspects to the column which is his character. On the face of one I should write "sincerity"; and on another, "dependability"; and on another, "high-mindedness"; and on the fourth, "courageousness". They add up to leadership. And there he stands, in Tennyson's phrase: "Four-square against the winds that blow."

Ruskin has said: "The highest reward for man's toil is not what he gets for it but what he becomes by it." And in that spirit we honor our retiring President tonight.

For all of you I know I speak when I say congratulations, Dr. Johnsen, and Mrs. Johnsen, too, who is inevitably so much a part of it, for a splendid year; and thank you from the bottom of all our hearts.

Now, ladies and gentlemen, it is my privilege to present to you Mrs. Thomas H. McGlade, retiring President of the Woman's Auxiliary to The Medical Society of New Jersey, who will give you a message of welcome. . . Mrs. McGlade.

Mrs. Thomas H. McGlade: Mr. Nevin, Dr. Johnsen, Honored Guests, Ladies and Gentlemen: The opportunity of saying welcome to all of you at this dinner honoring Dr. and Mrs. Johnsen is of special importance to me as President of the Woman's Auxiliary.

This year we celebrate our twenty-fifth anniversary.

We feel that Dr. Johnsen, Dr. Fritz, and the members of The Medical Society of New Jersey, through their generosity and understanding, have contributed much to the success and expansion of our programs.

The establishment of an Auxiliary office, with the valuable assistance of Mrs. Edith Madden and her staff, has added greatly to the efficiency and progress of Auxiliary endeavors.

We are extremely grateful to be able to report the granting of fifty-four nurse scholarships.

Two state and twelve county public relations meetings, and ninety-three rural and community health program bookings is, we feel, something of which we can be justly proud. however, our future programs are planned to be considerably broader.

We wish to thank the members of the Cumberland County Medical Society for permitting us to form an Auxiliary in their county.

Auxiliary members stand ready to implement or further any projects suggested by the Medical Society. We shall continue to inform the public of American medicine and present authentic facts concerning health education.

The Toastmaster: Thank you, Mrs. McGlade.

Very probably introductions are not necessary in a gathering so well acquainted and so friendly as this, but protocol insists that they be made. Therefore, it is now my function to present to you Mrs. Edward H. Dyer, President-Elect of the Woman's Auxiliary to The Medical Society of New Jersey.

And to her left, Dr. Harrold A. Murray, President-Elect of The Medical Society of New Jersey.

Now, that the rest of the guests at the table may not linger in anonymity, may I introduce to you, proceeding from the right toward the center, all those upon whom later I will not call?

Second from the end, therefore, is Dr. Edward Dyer.

Next to him, proudly beaming, Mrs. Harrold A. Murray.

If you haven't guessed about the next two, I'll tell you about them later.

Proceeding to the extremity of the table, we have Dr. Thomas McGlade.

Another lady who assuredly needs no introduction, Mrs. Aldrich C. Crowe.

And the lady of the evening, Mrs. Sigurd W. Johnsen.

I think at this time it would be unseemly and unfair to the audience not to introduce Dr. Sigurd Edward Johnsen and his charming wife.

And here is Dr. Ernest B. Howard, the Assistant Secretary of the American Medical Association and National Advisor to the Woman's Auxiliary.

Now follows the only thing that savors of ceremony in the whole program.

There is connected with The Medical Society of New Jersey an aristocracy of service which is called "The Fellows" — the Past-Presidents of The Medical Society of New Jersey. One has to *work* his way into membership here, and membership is conferred as an accolade.

As Dr. Crowe immediately preceded Dr. Johnsen in this select Fellowship, so now, as it were, he is permitted to take him by the hand and lead him to this membership of dignity.

The Fellow's Key will be bestowed, therefore, upon Dr. Johnsen by Dr. Aldrich C. Crowe.

Dr. Aldrich C. Crowe: Mr. Toastmaster, Sig, Ladies and Gentlemen: It is always a privilege for a former President to present the Key to the outgoing President, but this year it is extremely important to me and a great happiness because Sig Johnsen and I are very fine personal friends.

Sig, you have done a grand job. And after tomorrow, when you get to the House of Delegates and all the Medical-Surgical Plans are settled, you won't have any gastric ulcers to form and there will be sunshine on the boardwalk.

The Key that I will present to you symbolizes the fact that you are now a Fellow of The Medical Society of New Jersey. We are very happy to have you with us. You have done a grand job; you have made an excellent President; and I will certainly be happy to be able to see you again on a social basis and not a professional and business basis.

(During the presentation of the Key the audience arose, applauded, and sang "For He's a Jolly Good Fellow".)

President Johnsen: There are times and events when the most eloquent words fail to express in any adequate sense the feelings which I now have on this occasion.

As I look back over this year, I am so grate-

ful to you all for the wonderful way you have treated me.

I think of the Board of Trustees—the many meetings I have called, possibly unnecessarily, but always with the cooperation of the Board. I never heard from them a criticism for my shortcomings. And to the Board—I am very grateful.

To my fellow officers, particularly to Dr. Harrold A. Murray, who always was by my side; when I couldn't make an appointment, he was always there to carry on—to Dr. Decker and Dr. Lance, Dr. Greifinger, and to all of the officers—"Thank you" from the deepest depth of my heart.

To all of the members who have served on committees, who have worked so earnestly and continually—it has been the greatest pleasure of my life to have cooperation from every county, every committee; not once during the entire year have I asked any man to do anything, who hasn't cheerfully and willingly done it. It is something I'll never forget.

Mrs. McGlade has never asked me any questions I couldn't answer. She hasn't given me any hard times; she has cooperated. And we have now learned to look on the Woman's Auxiliary as our most valuable ally, and God bless you all, because you have been wonderful.

Last but not least, to the girls in the office force, under Mrs. Edith Madden, who have so bountifully helped in every way, my sincere thanks.

And to Mr. Richard Nevin—I have had the pleasure of having some little part in his appointment as our Executive Officer—you can see readily after that introduction why I picked him out—he has been a very faithful worker, and he has contributed more to the good name of The Medical Society of New Jersey in one year than any other single individual that I have had the pleasure of knowing. And to you, Dick, many thanks.

So, in behalf of Mrs. Johnsen and myself, I simply wish to say: From the bottom of my heart, thank you.

THE TOASTMASTER: From the information that I have and from the universality of his reputation, there is, I know, no need again of formal introduction of the speaker of the evening.

Contemplating the career and achievement of Congressman Judd—Dr. Judd in this assembly—I find myself recalling one of the phrases from Patrick Henry's speech on American liberty; that one in which he says: "There is a just God who presides over the destinies of nations, who will raise up friends to fight our battles for us." One such friend we have in Congressman Judd.

Republican member from the Fifth District of Minnesota since 1942, former medical missionary to China, Dr. Judd is one of the few members of Congress who can speak with personal knowledge and unimpeachable authority of the significance of events in Eastern Asia. He is no less an authority on the state of affairs in our national government. Tonight he has chosen to answer the question: What kind of government do we want?

I am honored to present your speaker, Dr. Walter H. Judd.

(The audience arose and applauded.)

Dr. Judd's address will be printed in full in one of the fall issues of the JOURNAL.

TRANSACTIONS OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

TWENTY-FIFTH ANNUAL MEETING

The Twenty-fifth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was called to order by the President, Mrs. Thomas H. McGlade on Tuesday, May 20, 1952, at Haddon Hall, Atlantic City. Invocation was given by Dr. George W. Lawrence, Pastor of the Ventnor Community Church. Roll was called by Mrs. Bertram Sauerbrun, Recording Secretary.

Mrs. Matthew Molitch welcomed Auxiliary members to the Convention on behalf of the Atlantic County Medical Society.

Mrs. McGlade introduced Mrs. Edward Dyer, President-Elect, who addressed the meeting and extended special thanks to Mrs. Harry Subin, Convention Chairman, in behalf of the Auxiliary. Mrs. Subin, in turn, presented the Convention Program and moved its adoption as printed. This motion was carried. Mrs. Richard Demaree moved that the minutes of the General Session of the Annual Meeting 1951 be approved as printed. The motion was carried.

The Memorial Service for deceased members was conducted by Mrs. William Dodd.

Mrs. David Allman, Parliamentarian, read the rules of order for the convention, which, on motion, were adopted.

The Treasurer's report, submitted by Mrs. Asher Yaguda, showed a balance of $3,961.15. The auditor, Mrs. William Roberts, reported the Treasurer's books to be accurate and complete.

Both these reports were approved and accepted.

Mrs. Frank Forte, First Vice-President, took the chair during the reading of the President's report by Mrs. McGlade. Her report was accepted with appreciation by the meeting.

The Credentials Chairman, Mrs. Samuel Winn reported 235 registrations of members and guests for this convention.

Mrs. McGlade announced that the reports of the Chairmen of Standing Committees and the reports of the County Presidents would be accepted as printed in the Booklet of Annual Reports. The following chairmen were called upon for brief reports:

Archives—Mrs. William E. Dodd
Bulletin—Mrs. Joseph E. Mott
Civil Defense—Mrs. Paul E. Rauschenbach
Finance—Mrs. Robert B. Walker
News-Note—Mrs. D. Leo Haggerty
Organization—Mrs. Ralph K. Bush
Parliamentarian—Mrs. David B. Allman
Press and Publicity—Mrs. Stuart Z. Hawkes
Public Relations—Mrs. Stewart F. Alexander
Rural Health—Mrs. Richard H. Demaree
Safety—Mrs. Jesse T. Glazier
Widows and Orphans—Mrs. John C. Voss

The following County Presidents were recognized for reports:

Atlantic—Mrs. Matthew Molitch
Burlington—Mrs. Edward F. Mazur
Camden—Mrs. Harold F. Westcott
Cumberland—Mrs. Albert B. Kump
Essex—Mrs. John J. Torppey
Hudson—Mrs. Morris Bresev
Mercer—Mrs. Charles C. Cohan
Middlesex—Mrs. Norman Rosenberg
Passaic—Mrs. Theodore K. Graham
Salem—President's report given by Mrs. Louis Silverman
Union—Mrs. Austin J. Tidaback

Mr. Richard Nevin, Executive Officer of The Medical Society of New Jersey presented the guest speaker of the Session, Mr. James Murray. Mr. Murray spoke of the diplomatic and social impact of the United States on the world today and the obligations thus incurred.

Mrs. Stuart Hawkes awarded the Press and Publicity prize for the best Clipping Notebook to Essex County.

Mrs. Andrew Ruoff, Revisions Chairman, presented a report on revisions. The following amendment to the Record Book of the Constitution and By-Laws was read:

Article IV Section 2 of our Constitution:

"The Woman's Auxiliary to The Medical Society of New Jersey shall not affiliate with other organizations, nor provide for representation on its Executive Board of representatives of other organizations, nor be itself officially represented on the boards of other organizations except with the approval of the Medical Advisory Board of The Medical Society of New Jersey".

Mrs. Ruoff moved that this amendment be approved. This motion was carried.

Mrs. Ruoff read proposed revisions to the Constitution of the Woman's Auxiliary to the American Medical Association. Mrs. David Allman as Past-President of the Woman's Auxiliary to the American Medical Association emphasized that the delegates to the National Convention must understand thoroughly the purpose of the revisions in question.

On motion of Mrs. Asher Yaguda, it was resolved that the delegates to the National Convention of the Woman's Auxiliary to the American Medical Association be uninstructed until they arrive in Chicago.

Mrs. Robert Walker announced that only those delegates who attended all the sessions of the National Convention are eligible to receive their financial allotment.

Mrs. Allman read the rules of the Nominating Committee.

The following candidates for the Nominating Committee 1953, were nominated from the floor:

Mrs. Robert Yuckman
Mrs. William E. Dodd
Mrs. Louis Wegryn
Mrs. John Johnson
Mrs. John Madara

Mrs. Thomas McConaghy and Mrs. Chester Ulmer were appointed as tellers for this election.

Having received the greatest number of votes, the members of the Nominating Committee 1953, were announced by Mrs. McGlade according to the report of the tellers: Mrs. Robert Yuckman, Mrs. William E. Dodd, Mrs. John Johnson, and Mrs. John Madara.

Mrs. R. John Cottone, Chairman of the Nominating Committee presented the slate for the Officers of the Woman's Auxiliary to The Medical Society of New Jersey for 1952-1953.

President—Mrs. Edward H. Dyer
President-Elect—Mrs. Frank S. Forte
First Vice-President—Mrs. Paul E. Rauschenbach
Second Vice-President—Mrs. Andrew C. Ruoff
Recording Secty.—Mrs. Bertram J. L. Sauerbrun
Corresponding Secty.—Mrs. J.S.D. Eisenhower, Jr.
Treasurer—Mrs. Asher Yaguda
Directors—Mrs. Ralph M. L. Buchanan and
Mrs. Lloyd A. Hamilton

On motion made, seconded and carried, the secretary cast a unanimous ballot for the slate as presented by the Nominating Committee.

Mrs. Don Epler offered the following resolutions:

Whereas, our President, Mrs. Thomas H. McGlade, has served the Woman's Auxiliary to The Medical Society, faithfully and well; and

Whereas, under her leadership the Auxiliary has grown both in interest and numbers; and

Whereas, her devotion to her duties, as president, has inspired the Auxiliary workers to their best efforts; therefore be it

Resolved, That the Woman's Auxiliary to The Medical Society at its twenty-fifth annual meeting, express to our retiring president, Mrs. Thomas H. McGlade, the grateful thanks and sincere appreciation of all members.

It was moved by Mrs. Epler and seconded by Mrs. William Dodd that this resolution be adopted. The motion was carried.

APPRECIATION TO DR. SIGURD W. JOHNSEN

Whereas, Dr. Sigurd W. Johnsen, President of The Medical Society, has advised and assisted the Woman's Auxiliary, and

Whereas, his friendliness has encouraged every officer and member who has had the privilege of knowing him, therefore be it

Resolved, That the Woman's Auxiliary to The Medical Society of New Jersey at its twenty-fifth annual meeting express to Dr. Sigurd W. Johnsen, the sincere appreciation of the Woman's Auxiliary.

It was moved by Mrs. Epler and seconded by Mrs. Stuart Hawkes that this resolution be adopted. The motion was carried.

THANKS TO DR. LEWIS C. FRITTS

Whereas, Dr. Lewis C. Fritts, Advisor to the Woman's Auxiliary, has given unstintingly of his time and efforts in promoting the Plans and Programs of the Auxiliary, therefore be it

Resolved, That the Woman's Auxiliary at its twenty-fifth annual meeting, express its thanks and sincere appreciation for these courtesies to Dr. Lewis C. Fritts, Advisor to the Woman's Auxiliary to The Medical Society of New Jersey.

It was moved by Mrs. Epler and seconded by Mrs. Frederick Wandall that this resolution be adopted. The motion was carried.

APPRECIATION TO MRS. EDITH MADDEN

Whereas, Mrs. Edith Madden, Administrative Secretary of the Medical Society has served the Woman's Auxiliary for many years in planning its structure in the Medical Society Headquarters in Trenton, New Jersey, and

Whereas, Mrs. Madden's friendly assistance, her courtesy at all times, her kindness and consideration have made possible many accomplishments of the Auxiliary, therefore be it,

Resolved, that the Woman's Auxiliary to The Medical Society of New Jersey at its twenty-fifth annual meeting, express sincere appreciation and heartfelt thanks to Mrs. Madden for her untiring efforts on behalf of the Auxiliary.

It was moved by Mrs. Epler and seconded by Mrs. Harry Subin that this resolution be adopted. The motion was carried.

APPRECIATION TO MRS. SUBIN AND COMMITTEE

Whereas, Mrs. Subin and her Committee have worked so diligently on behalf of the Woman's Auxiliary to The Medical Society of New Jersey and

Whereas, Mrs. Subin and her Committee, always having the best interests of the Auxiliary Members in mind, have planned so efficiently as to our enjoyment and comfort, therefore be it

Resolved, that the Woman's Auxiliary at its twenty-fifth annual meeting, express sincere appreciation and heartfelt thanks to Mrs. Subin and her Committee for their untiring efforts on behalf of the Auxiliary.

It was moved by Mrs. Epler and seconded by Mrs. Daniel Wilner that this resolution be adopted. The motion was carried.

APPRECIATION TO MISS LORENZO

Whereas, Miss Carmela Lorenzo has done yeoman service in compiling our records and has always been ready to help officers and chairmen when the need arose, therefore be it

Resolved, that the Woman's Auxiliary to The Medical Society of New Jersey, express sincere appreciation and thanks to Miss Lorenzo at its twenty-fifth annual meeting.

It was moved by Mrs. Epler and seconded by Mrs. Banks Baker that this resolution be adopted. The motion was carried.

APPRECIATION TO HADDON HALL

Whereas, The Woman's Auxiliary to The Medical Society of New Jersey in convention assembled May 1952, wish to convey to the management and staff of Haddon Hall, their cognizance of the many courtesies extended therefore be it

Resolved, that the Woman's Auxiliary express thanks and appreciation to all those who have extended these courtesies and helped to make this convention a memorable one.

It was moved by Mrs. Epler and seconded by Mrs. Austin Tidaback that this resolution be adopted. The motion was carried.

Mrs. Winn presented the final Credentials report. She announced 295 registrations at this convention.

Mrs. McGlade, retiring President, conducted the ceremony of the Installation of Officers and introduced Mrs. Edward H. Dyer, 26th President of the Woman's Auxiliary to The Medical Society of New Jersey.

Following her address Mrs. Matthew Molitch, President of the Atlantic County Auxiliary presented a gift to Mrs. Dyer in behalf of the County.

Mrs. Dyer read a message from Dr. Harrold A. Murray, incoming President of The Medical Society of New Jersey, thanking Mrs. McGlade and Auxiliary Members for their help during the previous year.

Mrs. R. John Cottone and Mrs. Robert B. Walker were appointed as the Reading Committee.

There being no further business to come before the General Session, Mrs. McGlade declared the Twenty-fifth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey adjourned.

IN MEMORIAM

Mrs. William E. Dodd, Archives Chairman

Forasmuch as Almighty God hath received unto Himself the souls of nine absent members we therefore tenderly pause in the regular order of the day to pay them our tribute.

Only a short twelve months ago they were with us but are now "In the deep stillness of that dreamless sleep that knows no waking joys again."

Because of their interest and activities in the work of the County Auxiliaries we shall miss them. We have known them as dear friends—kind understanding wives and mothers, and we pray their families who mourn them find comfort and understanding.

We do not question the wisdom of the One who gives life so mysteriously, then takes it away. We are sustained by His precious assurance and with faith commend unto His keeping:

from Bergen County.....Mrs. George Hoffman

from Burlington County..Mrs. Emlen P. Darlington
Mrs. Nathan Thorne

from Camden County....Mrs. Daniel H. Stephenson

from Essex County.....Mrs. Joseph C. Froelich
Mrs. Jacob Siegel
Mrs. Hugh F. Cook

from Hudson County.....Mrs. Hugh Tyndall

from Union County....Mrs. Z. Lawrence Griesemer

"We cannot think of them as dead
Who walk with us no more
Along the path of life we tread,
They have but gone before.

"And still their silent ministries
Within our hearts have place
As when on earth they walked with us
And met us face to face."

TWENTY-FIVE YEARS AND A SALUTE TO ATLANTIC CITY*

We are meeting today, as usual, in Atlantic City where we have assembled for all but four of our annual conventions since the founding of our Auxiliary a quarter of a century ago. And still we come in ever increasing numbers! Throughout these many years we have enjoyed the gracious hospitality, the warm friendliness, the unostentatious courtesies, and the efficient meetings arranged with artistic perfection by Atlantic County. It is beyond the comprehension of our membership to understand how one auxiliary can entertain many of the same people at *twenty-four* state and *six* national conventions with the same contagious enthusiasm that characterizes this 1952 meeting.

And so today we salute you, members of Atlantic County Auxiliary, for your selfless service. You have made us feel happy and at home as we have played and worked together; you have sustained and strengthened our Auxiliary; you have made history by giving us our organizer (Mrs. Samuel Barbash), our one National President (Mrs. David B. Allman), three state presidents, and now a president-elect. You have contributed to your community's health education program. For all this we can only gratefully say, "thank you; thank you very much indeed".

Now a birthday is a time for rejoicing. Twenty-five years old! It has been a good twenty-five years, filled with joy, struggles and achievements. Let us recount together for a few moments some of our experiences.

There are many of you here who can well remember the birth of our Auxiliary on June 9, 1927, and some of you will recall the plans which preceded it. The Medical Society of New Jersey, voted unanimously at its 160th annual meeting, June 1926 (after hearing an address by Mrs. W. Wayne Babcock, Chairman of Organization of the Woman's Auxiliary to the American Medical Association) to establish a state auxiliary. Following this meeting, Mrs. Samuel Barbash was appointed chairman of a committee to organize auxiliaries in each county in the state. When The Medical Society of New Jersey convened in Atlantic City on June 9, 1927, Mrs. Barbash reported that 14 counties were organized and that five others were in the process of formation. She then presented the names of the first *temporary* officers who later were duly elected as the *first* officers of the Woman's Auxiliary to The Medical Society of New Jersey in the Gold Room of the Chalfonte Hotel, Atlantic City. These were:

President, Mrs. A. Haines Lippincott, Camden County
President-Elect, Mrs. George L. Orton, Union County
First Vice-President, Mrs. Walter P. Conaway, Atlantic County
Second Vice-President, Mrs. Ephraim R. Mulford, Burlington County
Third Vice-President, Mrs. Frank Devlin, Essex County
Recording Secretary, Mrs. A. Longstreet Stillwell, Somerset County
Treasurer, Mrs. James Hunter, Jr., Gloucester County

Directors:

Mrs. Frank C. McCormack, Bergen County
Mrs. Richard M. A. Davis, Salem County
Mrs. Theodore Teimer, Essex County
Mrs. Reeve L. Ballinger, Hudson County
Mrs. Charles M. Gray, Cumberland County
Mrs. William G. Herrman, Monmouth County

When the state Auxiliary was founded it had a membership of 400. Today it has nearly passed the 2000 mark with 19 auxiliaries organized and one in the making. This growth is distinct evidence of the faith in our Auxiliary.

Since its inception 25 years ago our Auxiliary has held resolutely to its original objectives, although its program has been expanded to fit the needs of the times. Promoting good fellowship among physicians' families has been our first aim. Our second goal has been to assist The Medical Society of New Jersey in its service to humanity. The first goal has been very successfully attained through our working together over the years for worthwhile philanthropies. The amount of money that has been earned by our combined auxiliaries over a 25 year period, for various health and welfare organizations, is truly amazing. Substantial amounts have been contributed to hospitals, "Kiddie Keep-Well Camps", blood transfusion funds, Red Cross, tuberculosis centers, Y.W.C.A.'s, Cancer—to mention only a few. One of our greatest philanthropies has been our Nurses Scholarship Fund. Within the past year alone we have contributed over $6000 for scholarships throughout the state.

* Written by Mrs. Oswald R. Carlander, Historian, for presentation at a tea, May 19, 1952, in Haddon Hall, Atlantic City. The tea honors Atlantic County Auxiliary for its years of service as convention hostess.

Thus through pooling our efforts in social benefits, we not only have come to know each other better, but also have had the pleasure of helping others.

Another important benevolent project which has been emphasized by the Auxiliary since its earliest years is the "Society for the Relief of the Widows of the Medical Men of New Jersey". This year, county auxiliaries secured new members for this society among the doctors.

In reaching its second objective our Auxiliary has focused its attention on health education. It has carried on its work in a large variety of ways which cannot be given here for lack of time. However we note that standing chairmanships in Public Relations, *Hygeia* (now *Today's Health)* and Legislation have been maintained since our Auxiliary was established. This work has been greatly enlarged in scope in recent years by the addition of committees on Rural Health, The Chronically Ill, Nurse Recruitment, Safety, School Health Councils and the *News-Note*. Time does not permit a detailing of the multitude of contributions that our organization has made in these fields through the years, but a glance at notes on some of this year's achievements illustrates the wide scope of our endeavors:

PUBLIC RELATIONS

Two state-wide meetings to which leaders of lay organizations interested in the improvement of health facilities were invited. Topics for the forums were: "County Health Councils" and "A New Medical-Dental School for New Jersey".

Twelve county Public Relations symposiums and institutes on vital health subjects.

NURSE RECRUITMENT

Twenty-nine new nurses' scholarships were established this year, making a total of fifty-four throughout the state. A state-wide essay contest was conducted on the topic "Why I Want to be a Nurse". Close cooperation with high schools has been achieved. The New Jersey State Department of Education suggested the sponsoring of "Future Nurses' Clubs" in high schools to the Auxiliary and formative plans are under way. One Auxiliary member even interested a doctor in arranging a program with a high school in his community whereby students planning to be nurses could work afternoons in his hospital.

COMMUNITY HEALTH PROGRAMS

Ninety-three bookings of health programs with films and literature. Co-sponsors: The New Jersey Department of Health, The New Jersey Division of the Cancer Society, and the New Jersey Society of the American Academy of Pediatrics. The audiences for these meetings were large. For example, Mercer County was responsible for 6490 children in ten schools viewing dental films during Dental Health Week.

LEGISLATION

Twelve Auxiliaries have programs on medical and health legislation. Some have studied state and national health bills and have taken action as individuals. The Auxiliaries also followed out a request by the Medical Society to oppose a bill permitting the licensure of chiropractors. More resolutions against compulsory health insurance were secured and there has been much literature distributed on voluntary health insurance.

SPEAKERS' BUREAU

The Auxiliaries have referred many organizations to the "Speakers' Bureau" of both state and county medical societies for health programs. Thirty-two doctors have been placed as speakers.

PUBLICATIONS

Three hundred and thirty-three copies of *Today's Health* have been placed in high schools and county libraries, doctors' offices and have otherwise been made available to the public.

Three hundred and twelve members subscribed to the official *Bulletin* of the Woman's Auxiliary to the A.M.A.

Two well edited issues of the *News-Note* totaling 15 large pages have been sent to all Auxiliary members to acquaint them with the program and the responsibilities of the Auxiliary.

CENTRAL OFFICE

The establishment of a separate Auxiliary office with an administrative secretary has greatly aided expanding Auxiliary activities. This was made possible through the generous financial support of the Medical Society.

IN REVIEW

In considering the work accomplished through the years, we observe a progressive pattern. From self-education on health matters among our members, we have moved to the community with informative health programs both on county and state-wide basis. We have benefited increasingly from the generous financial support and guidance of The Medical Society of New Jersey in our health projects. Further, with the approval of the

Medical Society we have come to work more closely with the Departments of Health, Education and Welfare of the state of New Jersey.

IN PROSPECT

Since we are a relatively small group because of a selective membership of doctors' wives, mothers or unmarried sisters, we can look with pride upon the many achievements during our first twenty-five years. And what about the future? Our next twenty-five years should even be more fruitful. We know so much more than we did about working together and with The Medical Society of New Jersey; we have developed better administrative technics; we know more about health education and sense more the opportunities we have as an organization for health services. As we go forward may we ever remember that it is a privilege to be identified with a profession which has committed itself to the service of mankind and may we be alert to grasp the opportunities and responsibilities that come to us.

LUNCHEON ADDRESS

MRS. THOMAS H. MCGLADE, President

The celebration of our twenty-fifth anniversary makes this luncheon a very special occasion. It is our opportunity to acknowledge the leadership and unselfish efforts of our past presidents. The many accomplishments of the Auxiliary have resulted from the combined achievements of these presidents, state chairmen, county presidents and individual members. Together, they have completed twenty-five years of service to The Medical Society of New Jersey and to the public.

I am grateful for the opportunity this year has afforded me, to share with you, the responsibilities, satisfactions and privileges, that come to us, as physicians' wives, of belonging to the Auxiliary.

We can be proud of the recognition the Auxiliary has received. It has been called the greatest potential force the Medical Society has in the field of public relations. This has been demonstrated by the groups willing to cosponsor and participate in our programs, the most recent having been the Dental and Bar Associations.

Health Education has been our main objective. It is important that, as physicians' wives we continue to be the leaders in this field.

Working together and making friends is one of the assets of the presidency. This was particularly true in my association with Virginia Dyer. She has been extremely interested and endeavored to become familiar with every facet of our Auxiliary program. We are to begin a new quarter of a century under the leadership of Mrs. Dyer. Let each of us pledge our loyalty and support to her and to the continued progress and continuity of our years of Auxiliary service.

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED.
NOT RENEWABLE AFTER 6 WEEKS.

DATE BORROWED	BORROWER
NOV 6 1957	Subpoena
FEB 1 [illegible]	[illegible]
MAR 30 [illegible]	Schneider
	Hollander